The Modern Hospital

APRIL 1961

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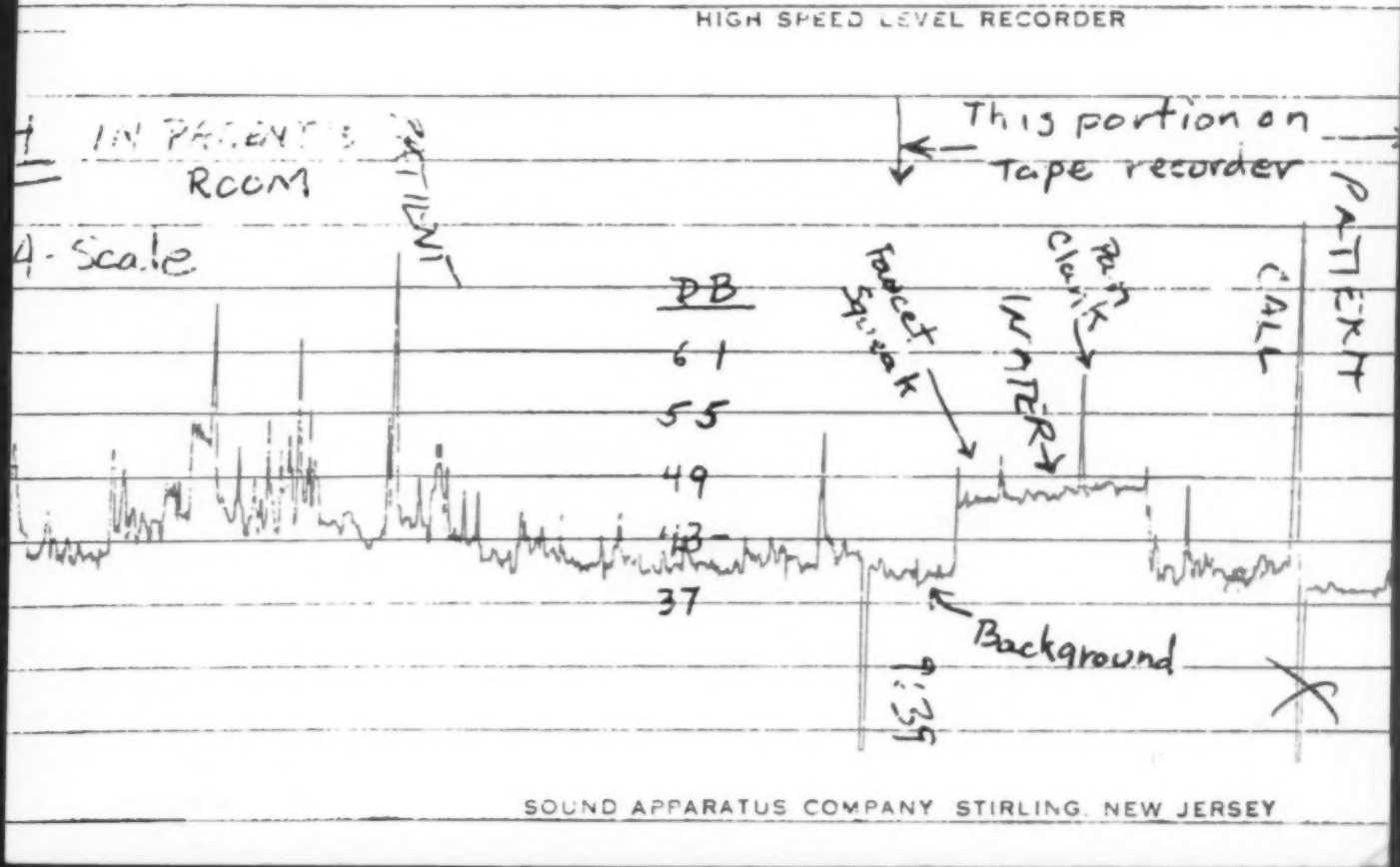

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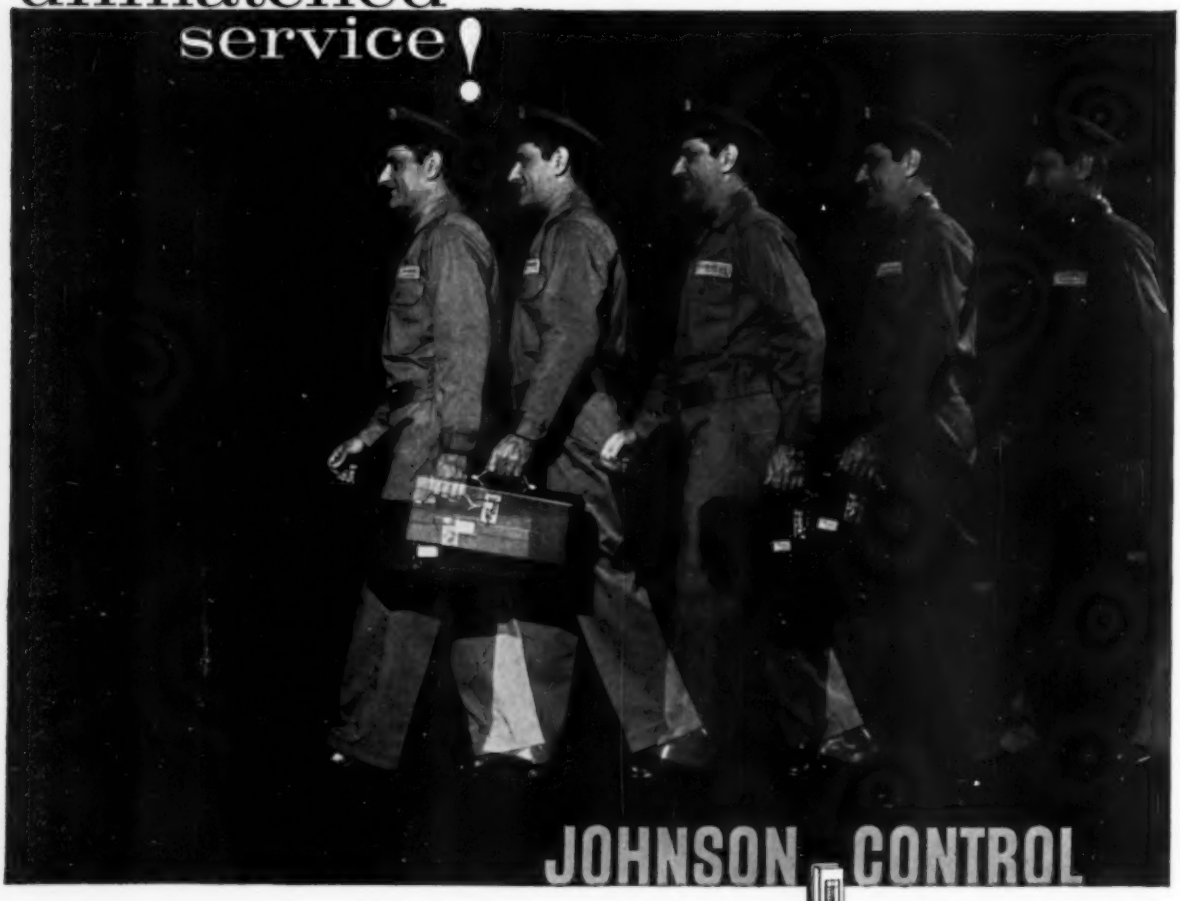

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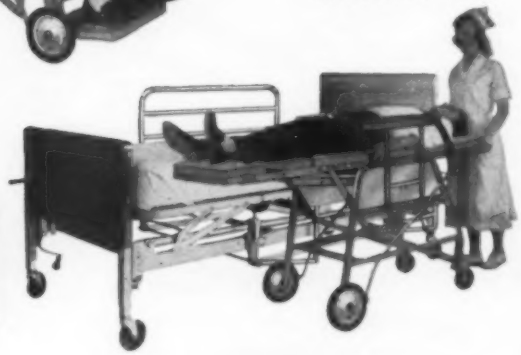

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The Modern Hospital

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READER OPINION

Are We Building Too Many Hospital Beds?

Sirs:

The report and analysis by Mr. London and Mr. Sigmond indicating that we may be building too many hospital beds* is very interesting. However, this study can be misleading and should be challenged to the full extent. It appears to be just a fluent use of words and juggling of statistics trying to justify a theory that is contrary to all concepts of planning, programing and foresight.

There may be a few hospitals to which this type of thinking can apply, probably less then 5 per cent of the national hospital total, depending upon each individual hospital's fixed and variable overhead per bed.

Additional information is required before one can make a true analysis of this theory, such as:

1. The individual characteristics or idiosyncrasies of each of the 14 hospitals studied.

2. Past, present and future trends of population, and hospital bed growth for each area served by each hospital.

3. The number of patients refused admission, for any purpose, during period studied.

4. Comparison of given data with the same data for January, February and March.

5. The meaning of the word "efficiently" as used in the discussion.

The efficiency of a hospital must also be considered in terms of its ability to perform services when needed, as well as cost per patient day. It may be considered economically and morally dangerous to reduce hospital bed capacity and not be able to meet peak demands. These are decisions that must be dictated by each individual community, served by each hospital, based on local facts and not theory.

It will be interesting to know the number of people, both hospital and public authorities, who challenge the sincerity of "Are We Building Too Many Hospital Beds?"

If enough challenges come forth, then the time and money spent in developing this doubtful report will be worth while and it will no longer be a question.

J. A. Millard, P.E.
Hospital Consulting Engineer
Lima, Ohio

*London, Morris, and Sigmond, Robert M.: Are We Building Too Many Hospital Beds? Mod. Hosp. 96:59 (January) 1961.

Authors' Reply

Sirs:

We appreciate Mr. Millard's comments that our article is "very interesting" and exhibits "fluent use of words." As to our "juggling of statistics," unfortunately Mr. Millard does not cite any examples. Since he also failed to identify the theory "that is contrary to all concepts of planning, programing and foresight" which he charges us with "trying to justify," we must remain silent on that score.

We are surprised that Mr. Millard believes that the value of our article should be measured by the number of people who challenge our "sincerity." The fact is that we are about the sincerest people we know. How many insincere people are working for hospitals and beating the drums

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for fewer beds? Foolhardy, probably! Theoretical, perhaps! Over-enthusiastic, possibly! But insincere we're not!

Mr. Millard and others may find answers to their questions in the following paragraphs of our submitted manuscript that now find their way into print for the first time:

"This is the first in a series of articles which present preliminary findings and some tentative conclusions from the Hospital Bed Occupancy Study now being conducted by the Hospital Council of Western Pennsylvania. This first article presents data on over-all occupancy and introduces the concepts of "constant" and "variable" vacancy rates. Subsequent articles will examine occupancy by service with special emphasis on maternity and pediatrics and the effect of weekends and holidays on occupancy. The data are being published at this time to stimulate discussion and consideration of validation studies by others in the field.

"The Hospital Bed Occupancy Study is supported by a Hospital and Medical Facilities Research Grant from the U.S. Public Health Service (Project W-141). The stated purposes of the study are to: (1) identify the factors which prevent a general hospital from operating at 100 per cent of capacity, including those factors that appear to be controllable by administrative action and those which are not subject to control; (2) explore maximum effective occupancy rates, and (3) analyze technics for achieving the highest possible occupancy consistent with effective service.

"Fourteen short-term general hospitals which are members of the Hospital Council of Western Pennsylvania are participating in the project. These hospitals range in size from 164 to 383 beds, with a median of slightly under 300 beds. About one-half of the participating hospitals are situated in Pittsburgh; the remainder are located within a 45 mile radius.

"Each participating hospital supplied daily census reports which gave the occupancy picture on each nursing unit. Collection of these census reports began Nov. 1, 1959, and continued for one complete year. Pending preparation of the final report, statistical data for the first four months of the study have been analyzed to pinpoint areas for future exploration. The four-month period extends from Nov. 1, 1959, through Feb. 29, 1960, and covers 121 calendar days.

"The variations in daily census are being analyzed in relation to weekends, weekdays, holidays and seasons over a continuous 366 day period. Data are being tabulated on the number of occupied and unoccupied beds for each nursing unit classified by bed size, service and other factors. Data processing is used to study statistically the occupancy pattern for each hospital as well as for the 14 hospitals as a group. Administrative practices and procedures in all of the hospitals are also under review in order to supplement the statistics and to determine the meaning behind them. Some of the areas that are being studied include: admitting and discharge procedures; check-out hours; allocation of beds according to pay status and service; flexibility in bed use; how scheduling in the operating room ties in with admitting practices; week-end admission patterns; availability of ancillary services on weekends; size and composition of medical staff, and the extent of multiple staff appointments. Wherever indicated by the data, the project

will single out the factors as they differ among hospitals with higher and lower occupancy rates."

The additional information about the 14 hospitals requested by Mr. Millard is lengthy and probably will be included in part in forthcoming articles or in the monograph to be published upon completion of the study. Such detailed data obviously could not be included in one article. Suffice it to say that the 14 study hospitals are all members in good standing of the Hospital Council of Western Pennsylvania and have as many idiosyncracies as any other 14 voluntary hospitals.

Data on population trends as mentioned by Mr. Millard, are not directly related to our study. Our concern is with the existing utilization of beds that are maintained in readiness to serve the public at any given time. We made no recommendations that either planning for the future or hospital construction cease.

Our thesis is really quite simple. When more beds are in use than are necessary to meet demand, either quality of care is threatened or community-wide cost of hospital service is increased, or both. As few beds should be used as are necessary to provide effective service. In exploring possible methods of accomplishing this objective, we have found that the variable vacancy rate in hospitals is subject to partial administrative control and can be cut in half in many hospitals without alienating patients or physicians and without adverse effects on quality. If the variable vacancy rate is controlled, hospital bed complement can be reduced *temporarily* or *permanently*.

The word "efficiency" as used in the article refers to provision of high quality care at lowest possible costs. Of course, bed capacity should not be reduced below peak demand, but why should the typical community maintain many more beds than peak demand? Does Mr. Millard — or any other reader — know of any multihospital community in which some beds have not been empty on every single day during the past few years, including peak days?

Morris London
Research Associate
Robert M. Sigmond
Executive Director
Hospital Council of
Western Pennsylvania
Pittsburgh

Banish Patient Gowns

Sirs:

Charter membership is now open in the S. D. P. E. D. P. G. H. — "The Society Dedicated to the Promotion of the Early Demise of Patient Gowns in Hospitals."

Twenty years ago, they made sense. Most patients were on strict bed rest and hospital rooms had no need for adjoining toilet facilities. In these days of early ambulation, do they still make sense?

Federal hospitals of the Army, Navy, Air Force, and Veterans Administration abandoned them years ago, substituting pajamas or, where necessary, so-called orthopedic pajamas.

Undeniably, federal hospitals have a majority of male patients, the reverse of voluntary hospitals. Pajamas may not be the most flattering attire ever donned by women, but patient gowns should be as obsolete as the bustle.

What's keeping the nation's voluntary hospitals? More than custom?

David V. Shaw
Hospital Consultant
Chicago

Exempt From Wage Law

Sirs:

When reviewing the Salary Survey: "Who Makes How Much in Hospitals?" (February, p. 96), we note that some nonprofessional occupations list wages below the minimum of $1 level.

Memphis, for instance, shows a wage scale of 48 cents.

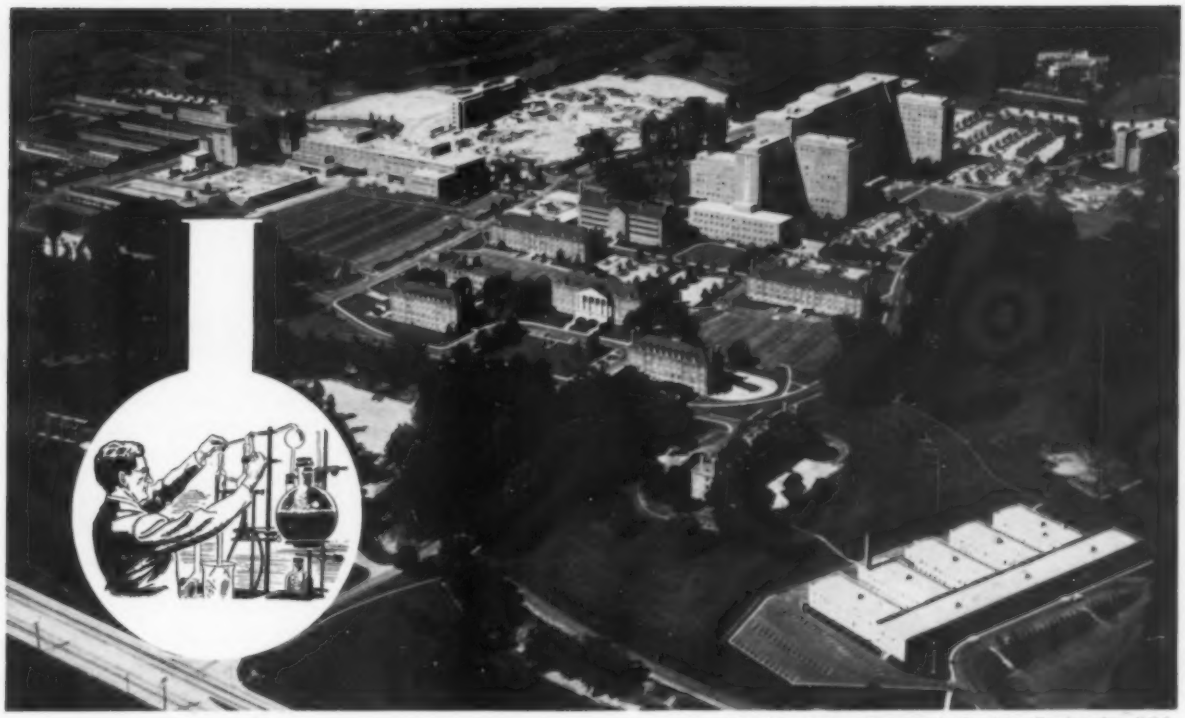
Can you explain?

Raymond W. Berg
Accounting Department
Avalon Memorial Hospital
Los Angeles

EDITOR'S NOTE: Governmental and nonprofit hospitals at present are held exempt from the minimum wages prescribed by federal law.

At present, legislation proposed in the Congress would extend the minimum wage provision to millions of additional workers, but the exemption now enjoyed by governmental and nonprofit hospitals is expected to be continued.

More information concerning this study can be obtained by writing the Bureau of Labor Statistics, Washington 25, D.C., or from the regional office nearest you.



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Recipe for Public Relations: Planning and Strong Support

By Gordon Davis

IF IT isn't organized, it isn't public relations. At least it is not a public relations program (stress "program") without meticulous basic organization.

Obvious as this point may seem, it often gets lost in the smog exuded by the production processes of public relations or in the smoke and soot of public relations fire-fighting.

But you can count on it: **If your public relations activity does not have laborious backing, it's falling short of its potential.**

What is sound organization? It is not unlike the organization that produces the meal which appears magically at the patient's bedside in the hospital. A lot goes before, and quite a bit comes after.

The first step toward the serving of a hospital meal is study of the customers and determination of their wants and needs. Some patients must have special diets; some can take standard fare; some must be spoon-fed; some can stow their vittles without supplementary aid.

Second is planning of the meals to meet the patients' requirements, to serve the purposes of good nutrition, and to appeal to the senses of taste, smell and sight. Serving of the meal is third, after which comes the cleanup, and, ultimately, the checking of results to determine whether the diet has been sound.

All of this is routine, habitual, mostly unexciting, repeated three times a day not counting snacks. All the patient sees is the food, the serving personnel, and the dishes. But consider the truly remarkable organization that makes this familiar performance possible. We more or less disregard it because we are so accustomed to it, but it is there.

It definitely is not there in many efforts which are presumed to be public relations. The activity is more comparable to the serving of cake. The cake may be delicious, but unsupported it scarcely constitutes a well balanced diet.

This all-frosting approach we should regard as an insult to the intellect, which surely is at least as difficult to nourish as the body. In our schools the curriculum is organized. Because it seldom deals with captive audiences, because its subject matter is often difficult, the public relations curriculum is in equal need of organization.

The administrator who is serious about public relations begins to progress when he seeks the answers to the same kinds of questions that he might ask about his food department.

Who are the people in need of this mental nutrition? What kinds of nourishing foods do they need? Which are the basic foods; which are the frills? How can the servings be made most palatable? After the fare has been served, what evaluation can be made to determine whether it has accomplished its purpose?

Above all, is the service systematic? Are the meals being distributed regularly? The recipes and the trimmings, the entrees, and the candelabra may vary, but are the nutritional essentials always there at the time they should be there?

Affirmative answers to these questions require as much behind-the-scenes activity as there is in the kitchen before and after meals, not just for special occasions but consistently, methodically, day in and day out. ■

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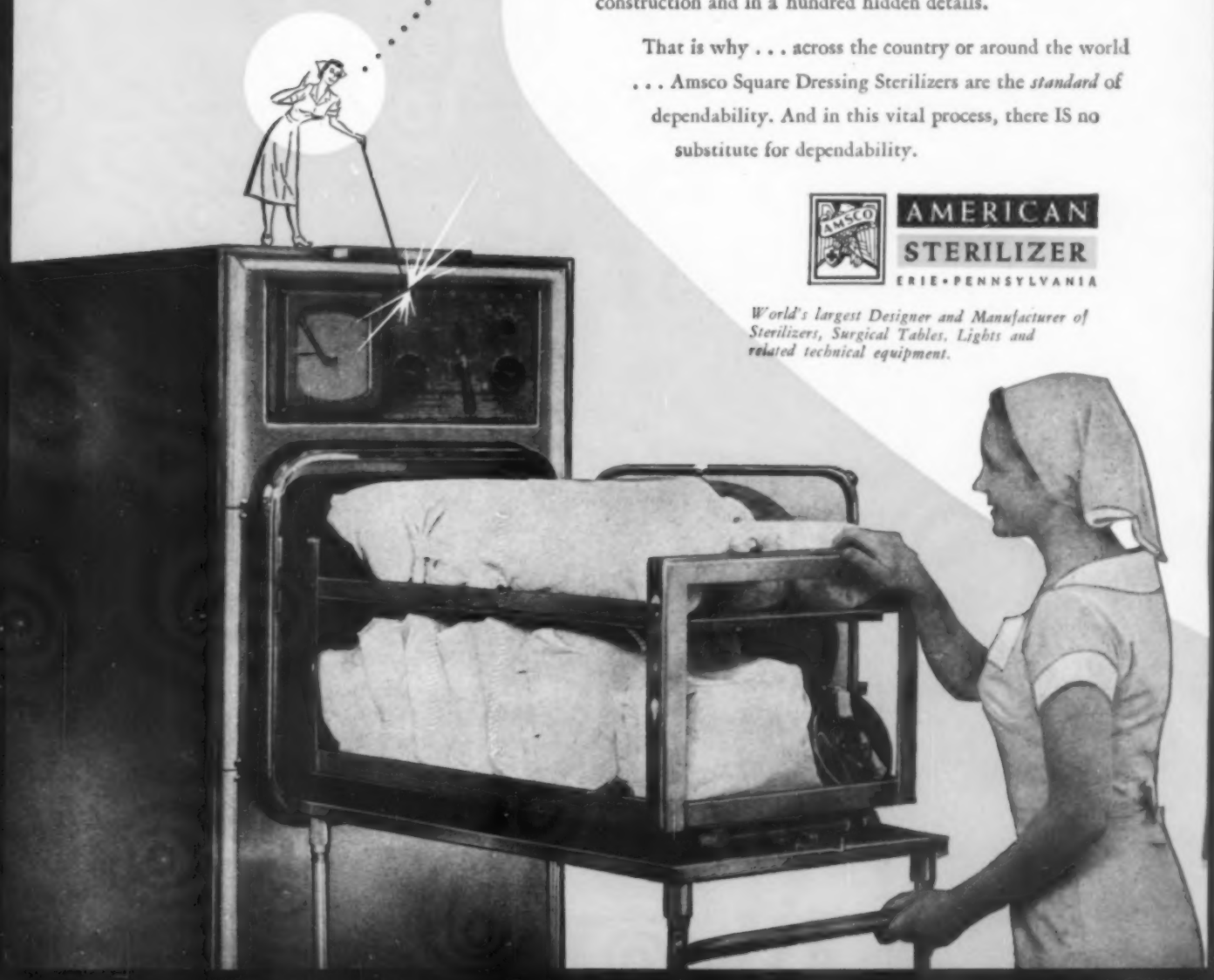
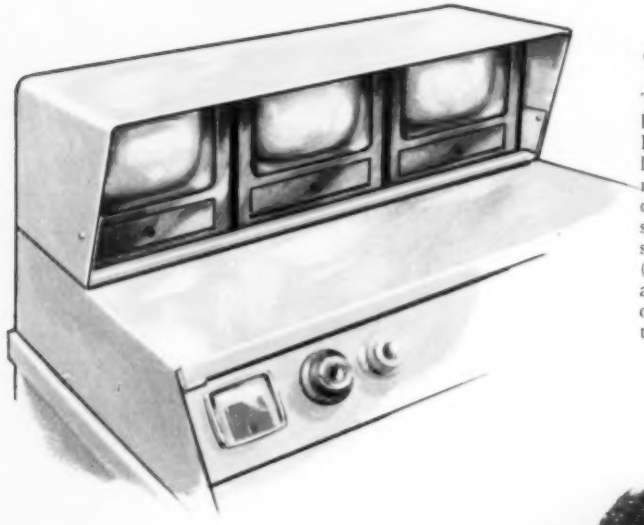


General Electric Teletrol—for x-ray diagnosis by remote control! A week-long demonstration of this new diagnostic x-ray system created tremendous interest at the December 1960 Cincinnati meeting of the Radiological Society of North America.

Pushbutton patient positioning!

Remote-control of x-ray table from master console: provides for manipulating patients lengthwise, crosswise, and for angulating the table 180°. X-ray tube (above table) and image intensifier (below) locked in permanent alignment—respond in unison to control commands. Power palpator (with pressure-sensitive cutout) also operates from the master console, along with adjustable-beam collimator. Other controls for regulating technic factors . . . cine recording . . . TV functions . . . and for making large-film spot radiographs. Built-in intercom for two-way exchanges with patients.

TELETROL
for remote-control diagnosis

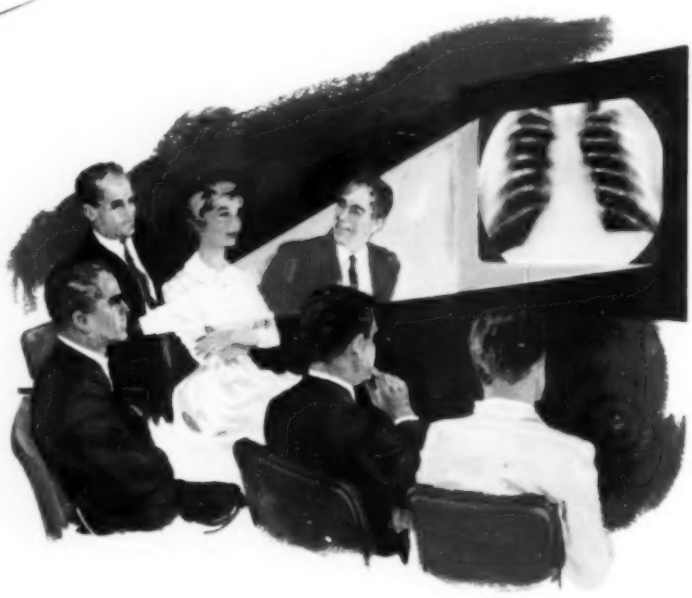


"Lightroom" TV fluoroscopy!

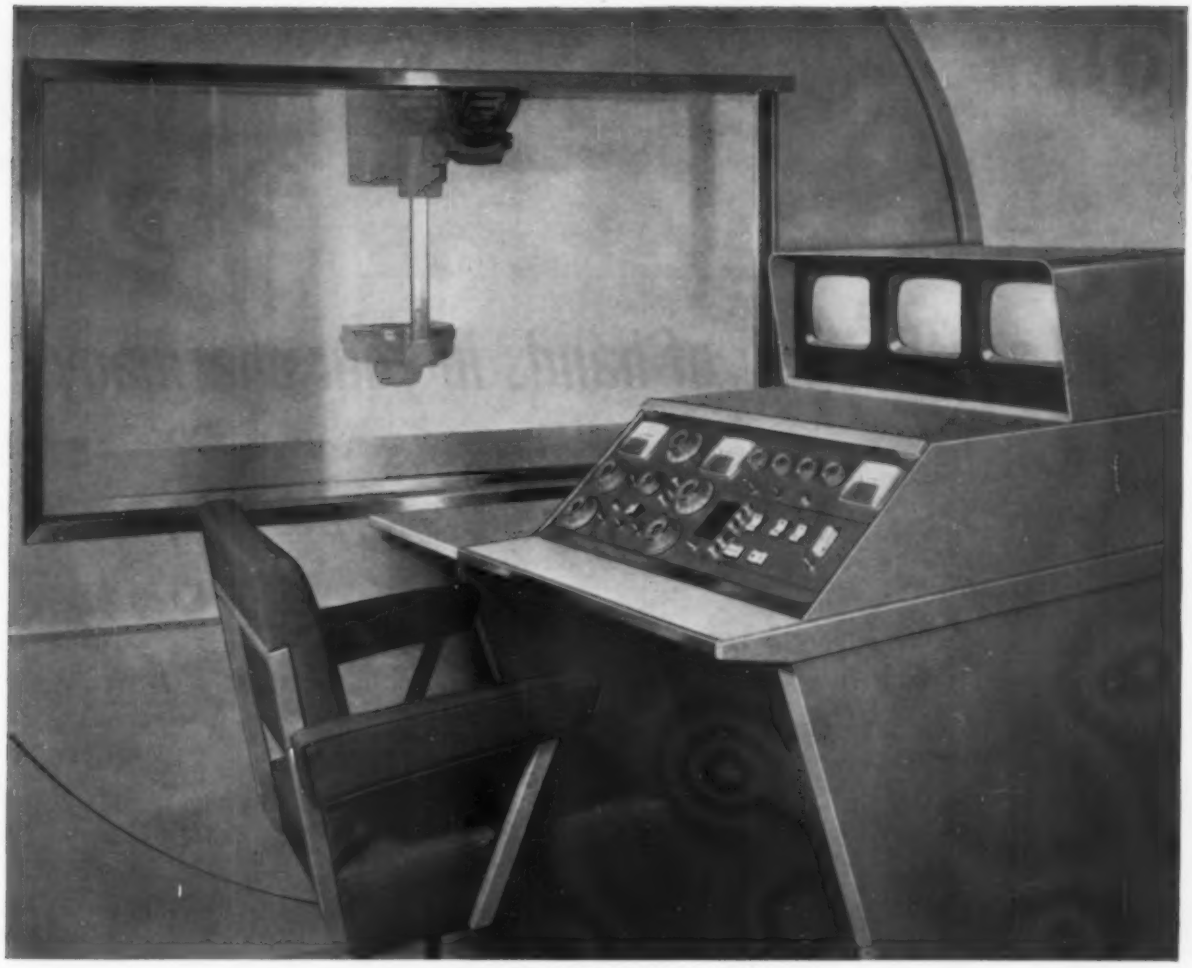
TELETROL'S TV monitor presents "lightroom-bright" fluoroscopic images with excellent resolution. Basic intensifier tube and ultra-sensitive TV pickup housed within x-ray table; further brilliance gain is realized in TV amplification circuits, yielding images of exceptional quality. System fully compatible with standard television, permitting closed-circuit transmission for teaching and consultation. Additional monitors (optional) can provide for observing the patient from another angle, remote checking of films in darkroom, or other desirable contacts through closed-circuit television viewing.

Remote cine-recording and radiography!

TELETROL makes cine-filming *push-button easy*—and clinically practical! Grid-controlled x-ray tube and pulsing system reduce patient exposure for cine-fluorography to the minimum. Automatic-brightness control monitors exposures for consistent cine-film quality. And spot films are actually full-fledged 14″ x 14″ stationary-grid radiographs made at 40-inch distance!



Litho in U.S.A.



. . . the future of x-ray awaiting your touch

Imagining himself at the controls of TELETROL, the radiologist will quickly realize that here remote control does not make him "remote" from the patient. Actually there is far less confusion and tension, now that darkness and protective clothing are unnecessary. Doctor and patient have direct visual contact at all times through the wide protective window that rotates with the table. Conversation is by intercom.

And obviously the elimination of delays for dark adaption and the lessening of physical strain on the radiologist promote greater comfort and efficiency.

Meet the future of x-ray today in TELETROL. Investigate its far-reaching potentials. Your G-E x-ray representative has complete information and can quote on your requirements. Or you can write to X-Ray Dept., General Electric Co., Milwaukee 1, Wis., Room 1102.

Progress Is Our Most Important Product

GENERAL ELECTRIC

Need another pair of hands in your pharmacy?

IF YOUR HOSPITAL is as overcrowded and as overworked as 90% of the hospitals today, you certainly need extra help. What a good many hospital pharmacists and administrators do not know, however, is that they can get the extra pharmacy help without increasing their operating costs. As a matter of fact they can even save money while increasing efficiency.

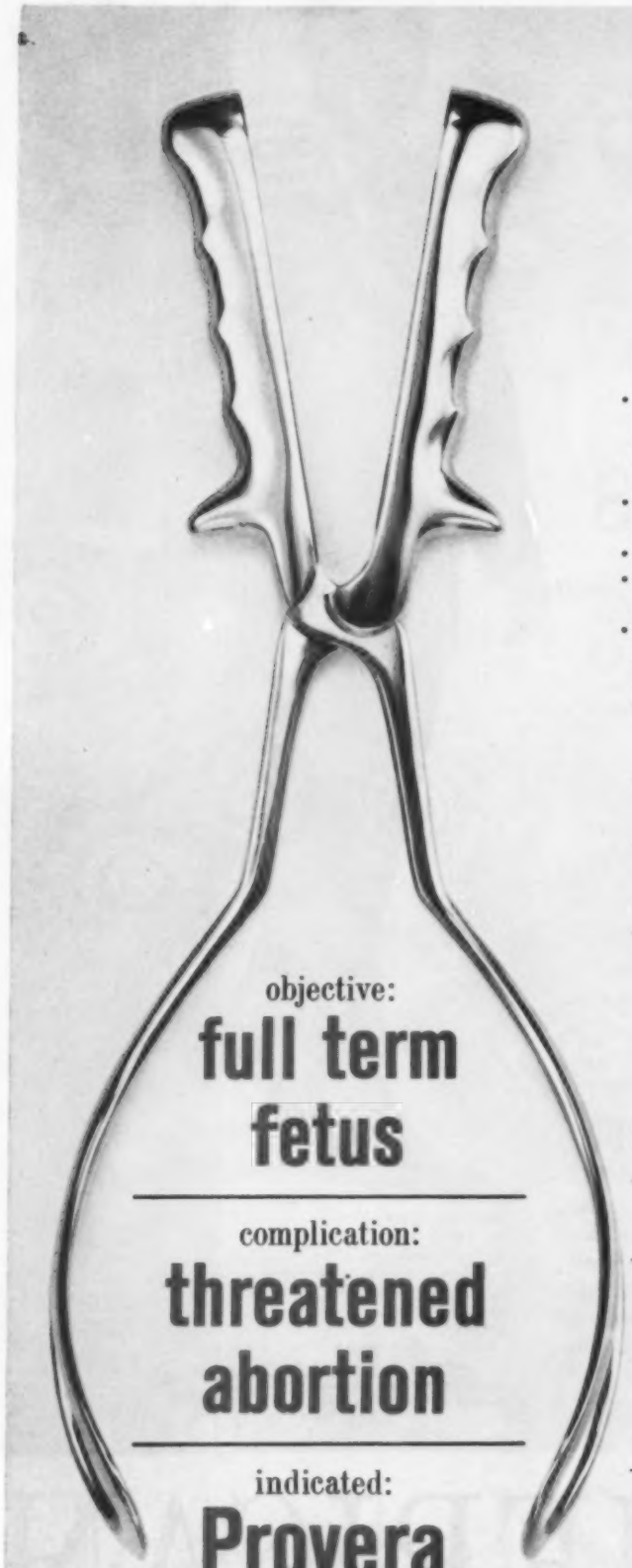
● The McKESSON & ROBBINS Hospital Service Representative will gladly become your extra man. He is more than a salesman, he is a trained hospital pharmacy specialist who can give you professional assistance and advice on the many problems of hospital drug management.

Take your drug inventory for example. Large inventories eat up valuable time in ordering and maintaining stock levels and crowd your space, but, more importantly, they increase your carrying charges, tie up money and increase the risk of loss due to deterioration, damage and obsolescence. The McKesson & Robbins Hospital Service Rep can help you establish a smaller in-hospital inventory based on sound drug levels in keeping with your medical needs. He will also help you select drugs produced by reliable manufacturers to meet your demands—and then will maintain your stock levels for you. This means the money and time costs of procuring and carrying supplies will be held at a minimum. A real saving for you.

With 91 McKesson & Robbins warehousing units across the country, each with a Hospital Service Department, you have a local source of drug and sundry supplies that is actually an extension of your own storage space. You are only a telephone call away from any drug product you might need in emergencies, as well as for routine service. Inventory control is but one of the reasons why most of the nation's hospitals depend upon McKesson & Robbins for economical and efficient management of their pharmacies.

We will be happy to send you the name of the McKesson & Robbins Hospital Service Department nearest you, or have our Hospital Service Rep call on you...just drop us a card, McKesson & Robbins, Inc., Hospital Service Department, 155 East 44th Street, New York 17, New York.

Serving America's Hospitals... **McKESSON & ROBBINS**



objective:

full term fetus

complication:

threatened abortion

indicated:

Provera

Upjohn

Here are five reasons why:

- Provera is the only commercially-available oral progestational agent that will maintain pregnancy in critical tests in ovariectomized animals.
- It is four times as potent (by castrate assay) as any other progestational agent.
- No significant side effects have been encountered.
- It is available for both oral and parenteral administration
- Provera gives the economy of effective action from small doses.

Brief Basic Information

	● Oral Provera*	I.M. Depo-Provera**
Description	Upjohn brand of medroxyprogesterone acetate.	Aqueous suspension, 50 mg. Provera per cc., for intramuscular injection only.
Indications	Threatened and habitual abortion, infertility, dysmenorrhea, secondary amenorrhea, premenstrual tension, functional uterine bleeding.	Threatened and habitual abortion, endometriosis.
Dosage Threatened abortion	10 to 30 mg. daily until acute symptoms subside.	50 mg. I. M. daily while symptoms are present, followed by 50 mg. weekly through 1st trimester, or until fetal viability is evident.
Habitual abortion		
1st trim.	10 mg. daily.	50 mg. I.M. weekly.
2nd trim.	20 mg. daily.	100 mg. I.M. q. 2 wks.
3rd trim.	40 mg. daily, through 8th month.	100 mg. I.M. q. 2 wks. through 8th month.
Supplied:	2.5 mg. scored, pink tablets, bottles of 25; 10 mg. scored, white tablets, bottles of 25 and 100.	Sterile aqueous suspension for intramuscular use only. 50 mg. per cc., in 1 cc. and 5 cc. vials.†

Precautions: Clinically, Provera is well tolerated. No significant untoward effects have been reported. Animal studies show that Provera possesses adrenocorticoid-like activity. While such adrenocorticoid action has not been observed in human subjects, patients receiving large doses of Provera continuously for prolonged periods should be observed closely. Likewise, large doses of Provera have been found to produce some instances of female fetal masculinization in animals. Although this has not occurred in human beings, the possibility of such an effect, particularly with large doses over a long period of time, should be considered.

Provera, administered alone or in combination with estrogens, should not be employed in patients with abnormal uterine bleeding until a definite diagnosis has been established and the possibility of genital malignancy has been eliminated.

†Each cc. of Depo-Provera contains: Medroxyprogesterone acetate, 50 mg.; Polyethylene glycol 4000, 28.8 mg.; Polysorbate 80, 1.92 mg.; Sodium chloride, 8.65 mg.; Methylparaben, 1.73 mg.; Propylparaben, 0.19 mg.; Water for injection, q.s.

The Upjohn Company, Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF. **TRADEMARK

First from American

New ideas, new products for dietary service...

through one service expert!

Your man from *American* understands dietary service needs. Working with Dietary Products representatives, he offers valuable experience and expert counsel in this as well as in every other hospital area . . . and the most complete selection of products and services. Your man from *American* is dedicated to your best interests . . . call him with confidence.

Dick Martin joined *American's* growing family after graduating from Michigan State with a B.A. degree in Business Administration. He was assigned to the Boston area in 1952 where he has been serving customers ever since. Dick's ever-increasing knowledge of hospitals and his ability to solve his customers' problems have won him many friends in Boston area hospitals.

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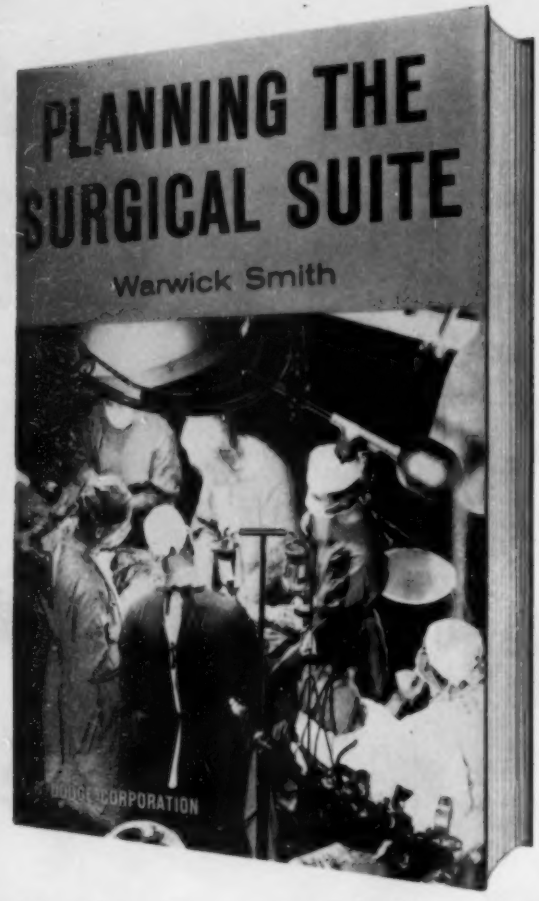
Winnipeg 12, Manitoba. In Mexico—Hoffmann-Pinther & Bosworth, S. A., Mexico 1, D. F., Mexico.



The first authoritative guide for planning the heart of the hospital

PLANNING THE SURGICAL SUITE

by Warwick Smith

456 pages, 6 x 9" size
with over 75 illustrations and
17 guide tables and charts
only $12.75

The heart of the hospital is its surgical suite. Because of its critical functions, the operating room and its environs must be designed to work efficiently under all conditions. This is a fact recognized by all administrators and designers of hospitals. Equally recognized is the difficulty involved in developing a truly efficient and flexible plan for a surgical suite.

Much time and money has been wasted in building and remodeling surgical suites. The inherent flaws are soon revealed in a suite design which did not consider all of its required functions. Consequently, within weeks of its occupation, it is often found necessary to remodel or improvise upon the original design.

PLANNING THE SURGICAL SUITE is aimed directly at this problem. This unique guide explains how the intended functions of a surgical suite affect its organization and design, and describes the methods of translating these into actual facilities. With the aid of tables, charts, and checklists, it provides for a complete analysis of the function and design of the operating room complex.

Hospital administrators, surgical supervisors, staff surgeons and anesthetists—anyone whose responsibility embraces the whole hospital operation, or is limited to the surgical area—will find PLANNING THE SURGICAL SUITE of vital interest.

Considers all aspects, including:

- **role of the surgical suite**
- **size, plan, and location**
- **traffic flow for both patients and staff**
- **storage for clean and sterile supplies**
- **sterilization facilities**
- **detailed arrangement of rooms**
- **materials and finishes**
- **heating, ventilation, and air-conditioning**
- **engineering services**

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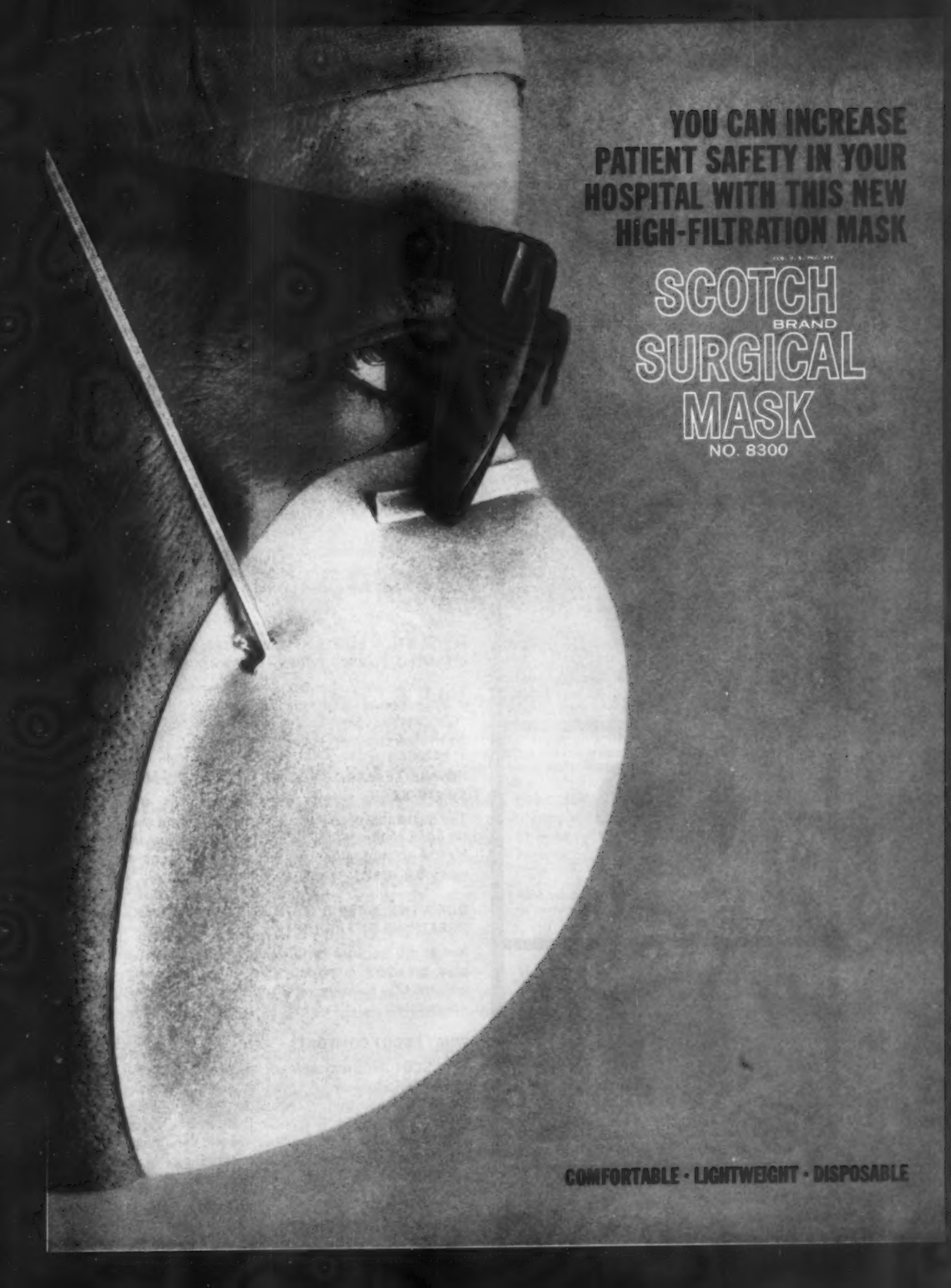
About the author . . . .

Warwick Smith has made an intensive, twelve-year study of hospital design, with special emphasis on the surgical suite. Although a native Australian, Smith has designed hospitals and medical facilities while working for architectural firms in England, Sweden, and the United States. An associate of the Royal Institute of British Architects and the Royal Australian Institute of Architects, the author was awarded the Henry Saxon Snell Prize in 1954 for research in hospital architecture.


YOU CAN INCREASE PATIENT SAFETY IN YOUR HOSPITAL WITH THIS NEW HIGH-FILTRATION MASK
SCOTCH
BRAND
SURGICAL
MASK
NO. 8300
COMFORTABLE • LIGHTWEIGHT • DISPOSABLE

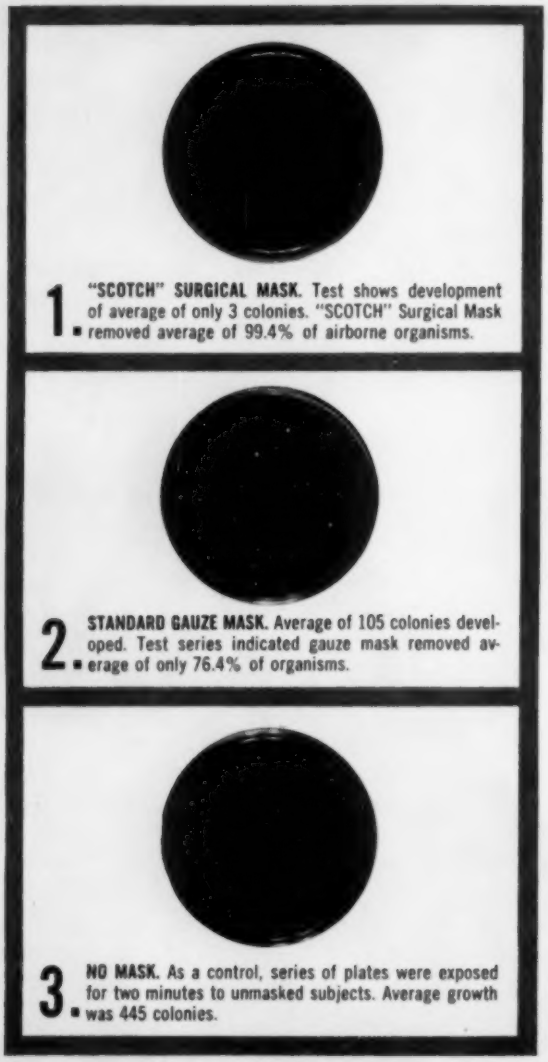
HERE ARE THE FACTS ON THE NEW SCOTCH® BRAND SURGICAL MASK

REG. U.S. PAT. OFF.

HOW DOES THE "SCOTCH" BRAND SURGICAL MASK COMPARE IN FILTERING EFFICIENCY WITH GAUZE MASKS?

In hundreds of controlled comparative tests (utilizing both in-use and mechanical sampling methods ... both new and used masks ... both brief and sustained testing periods) the "SCOTCH" Surgical Mask averaged up to 35 times more effective than gauze in filtering out airborne bacteria.

TYPICAL TEST RESULT: (masked subjects, 2 minute test period)



1 **"SCOTCH" SURGICAL MASK.** Test shows development of average of only 3 colonies. "SCOTCH" Surgical Mask removed average of 99.4% of airborne organisms.

2 **STANDARD GAUZE MASK.** Average of 105 colonies developed. Test series indicated gauze mask removed average of only 76.4% of organisms.

3 **NO MASK.** As a control, series of plates were exposed for two minutes to unmasked subjects. Average growth was 445 colonies.

WHY IS THE DESIGN AND CONSTRUCTION OF THE "SCOTCH" SURGICAL MASK SO EFFICIENT?

The "SCOTCH" Surgical Mask is molded of a new stabilized-porosity synthetic fabric with an unusually high filtration capacity. Unlike soft, woven fabrics such as gauze, its built-in porosity is permanent. There is little or no variation from mask to mask and no radical loss of efficiency due to compression, matting, or wetting during use.

HOW DOES THE CONTOURED SHAPE OF THE MASK INCREASE ITS FILTERING EFFICIENCY?

Because it is held away from the mouth and nostrils, virtually the entire inner surface of the "SCOTCH" Surgical Mask acts as a filter. Exhaled moisture droplets are not propelled through a small area, but are dissipated at low velocity within the mask.

MUST THE "SCOTCH" SURGICAL MASK BE CHANGED DURING PROLONGED PROCEDURES?

Rarely. Whereas gauze masks rapidly lose efficiency due to wetting and must be changed frequently, the "SCOTCH" Surgical Mask shows little or no drop-off in filtering effectiveness in extended use.

HOW IS LEAKAGE AROUND THE MASK EDGES CONTROLLED?

The adjustable nose piece, contour shape and elastic band of the "SCOTCH" Surgical Mask provide a close fit that minimizes air leakage. Fogging of glasses is almost totally eliminated.

DOES THE MASK'S HIGH FILTRATION MAKE BREATHING DIFFICULT?

Not at all. Because of its large effective filtering area, breathing is actually easy. There is no significant CO_2 build-up within the mask. Speech is not muffled.

WHAT ABOUT COMFORT?

The "SCOTCH" Surgical Mask has been called "the most comfortable yet." It is lightweight (9 masks weigh only one ounce). Measured skin temperatures have proved 1° cooler than inside gauze masks. Vision is not obstructed. Elastic band holds mask in correct position without slipping or binding. There are no strings to tie or adjust.

Enthusiastically accepted. The "SCOTCH" Surgical Mask shown in use in a leading midwestern hospital—one of the many institutions that have already standardized on this high-filtration disposable mask.

IS THE "SCOTCH" SURGICAL MASK EXPENSIVE TO USE?

No. An independent six-month cost study at a leading hospital showed virtually identical over-all costs whether the "SCOTCH" Surgical Mask or gauze masks were used. "SCOTCH" Surgical Masks cost approximately 9 cents each at quantity prices . . . eliminate all inspection, laundry and re-sterilization costs.

CAN THE MASK BE AUTOCLAVED?

Yes. While this mask is designed and priced to be fully disposable, it may be steam autoclaved with no loss of filtering efficiency.

HOW CAN YOU TRY THE "SCOTCH" SURGICAL MASK IN YOUR HOSPITAL?

Your surgical supply dealer can fill your trial order promptly—box of 50 masks, only $6.00; case of 10 boxes, $54.00†. Or, for free samples and additional literature, contact your 3M Sales Representative or write to 3M Company, Dept. NAN-41, 900 Bush Avenue, St. Paul 6, Minnesota.

†PRICES SUBJECT TO CHANGE WITHOUT NOTICE.

REG. U. S. PAT. OFF.

SCOTCH BRAND SURGICAL MASK*

NO. 8300

MINNESOTA MINING AND MANUFACTURING COMPANY

...WHERE RESEARCH IS THE KEY TO TOMORROW

3M

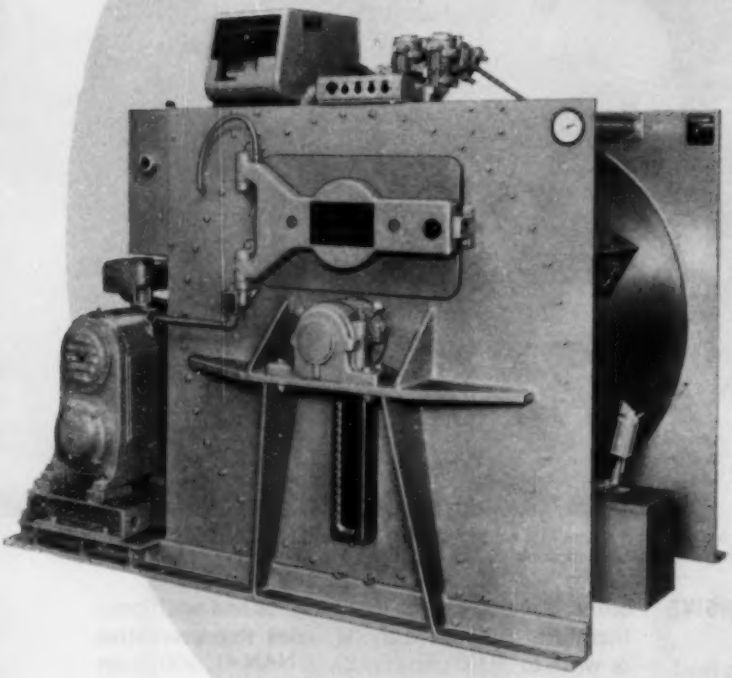
*PATENT PENDING

"SCOTCH" is a registered trademark of 3M Co.

Which one is

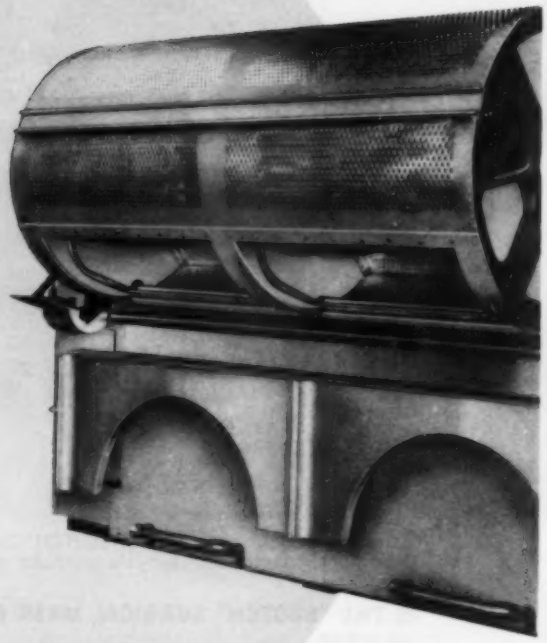
if your volume is 900 lbs. per hour, or less . . .

WASHER-EXTRACTOR!



if your volume is more than 900 but less than 1800 lbs. per hour . . .

UNLOADING WASHER!



It's just that easy. And what's more, we can prove it! This greatly simplified rule-of-thumb is based on a series of calculations which relate a laundry washer's production per sq. ft., and investment per lb. produced to specific hourly volumes.

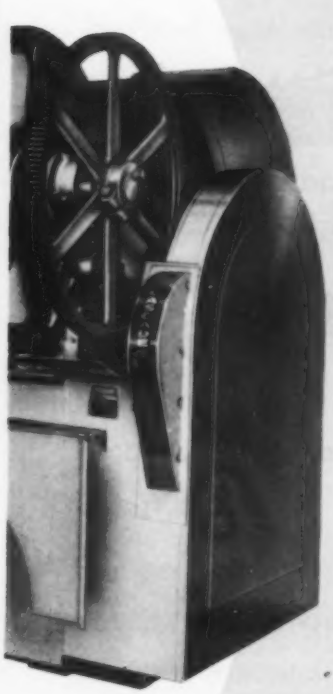
This will give you an accurate picture of the economy and efficiency you can expect from any type and size laundry washer — *before you buy!* It is the only way you can be sure that the machine you select is best suited to handle *your* specific laundry requirements.

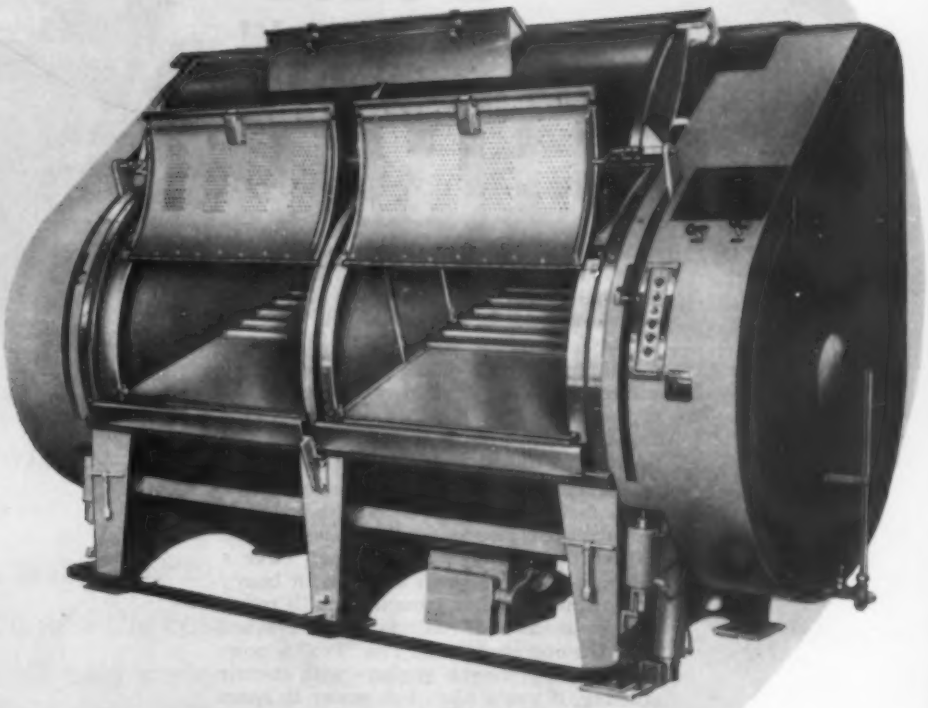
Give your nearby American representative just a few minutes and he'll show you how this simple yet foolproof system will enable you to select the *right* machine every time. Call him today or write for complete information.

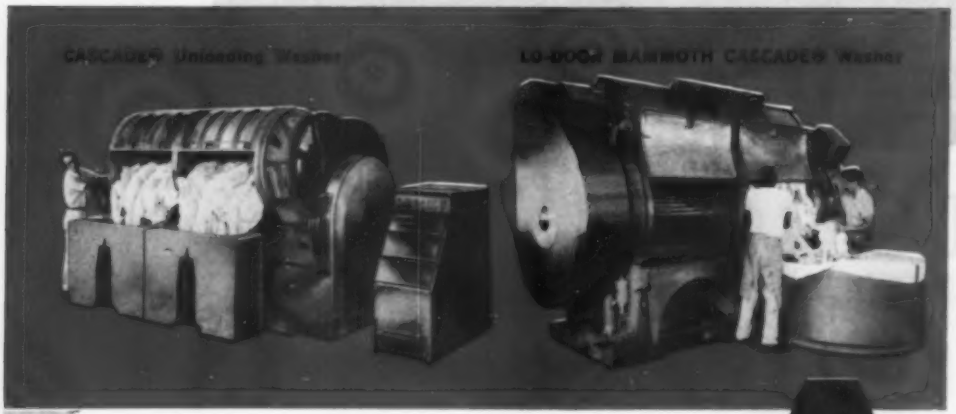
right for you?

if your
volume exceeds 1800 lbs.
per hour . . .

BIG-VOLUME WASHER!







Because we offer such a wide range of laundry washroom equipment, you can always be sure that your American representative will recommend only the type and size machines which are exactly suited to your particular needs. With nine types and twenty-six sizes of washers and washer-extractors to work with, he has no ax to grind. You'll get the right machine every time.

You get more from **American**

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Now! "Pivot-Power" steering on the TORO Professional*!

(and you can lease it for a few cents an acre under the new Toro Fleet Finance Plan. Write Toro Manufacturing Corp. for complete facts!)

A SQUEEZE of one of the hand levers is all it takes to turn the mighty Toro Professional quickly to right or left. No other reel mower of its size gives you such remarkable handling ease.

Think what this means in terms of time and money! Your "Pro" can be operated at high speed—since there's no need to slow down to make turning easier. Less wear and tear on the operator, too.

Yet the "Pro" is more than merely quick on its feet. It's flexible. Three 6-blade reels are mounted independently—"floated" on adjustable springs—so they can have a featherweight touch on soft turf, a heavy hug on hard, rough ground. The "Pro" is easy to handle. All controls can be reached from the operator's seat. The "Pro" is powerful. A 9 hp, 4-cycle engine—with electric starting, if you'd like—has power to spare for climbing hills and slopes.

Like a demonstration? Simply call or write your nearby Toro distributor. He'll be glad to prove the "Pro" on your own grounds—show you how it can pay for itself the first year!

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TORO

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There's no fine print in Onan's pricing policy!

'Strip-downs' and 'price-adders' are getting out of hand in the electric plant industry. There have always been a few who have sold strictly on price, and of course, got the price down by stripping equipment of essential components.

Today, some leading manufacturers are stripping-down their electric plants.

These stripped-down prices *are* attractive. But when you add the cost of such essentials as oil and water pressure gauges, battery-charging ammeter, over-speed shutdown, radio suppression, flexible exhaust tubing—*even mufflers!*—what happens to your bargain price? You're right—you wind up paying more.

Onan has never produced a stripped-down model, has never used essential operating accessories as 'price-adders.'

Today, more than ever, it will pay you to go over electric plant prices with an eagle eye. *Compare Onan prices with others before you buy.* (But read the fine print.)

C. W. Onan, President

Onan Electric Power Plants are available in sizes from 500 to 230,000 watts.

World's leading builder of electric power plants

Onan

ONAN Division, Studebaker-Packard Corporation, 2639 University Avenue S.E., Minneapolis 14, Minn.

How Dial Soap can help curb the staph problem in your hospital

Routine use by personnel and patients suggested as aid in eliminating one source of infection

The antibacterial ingredient in Dial—a synergistic combination of hexachlorophene and trichlorocarbanilide—has long been known for its effectiveness against the skin bacteria that cause perspiration odor.

Now, new and more extensive tests have established that Dial inhibits the growth of a wider range of gram-positive and gram-negative bacteria—including strains that are resistant to antibiotics—than any other leading toilet soap.

Many physicians already recommend the use of Dial to their patients. And now, this new evidence points up, even more sharply, the benefits of Dial for hospitalized patients and hospital personnel.

Costs no more than other popular soaps . . . comes in three hospital-tested sizes

With its uncommon antibacterial benefit you might expect to pay extra for Dial—but you don't. Trim costs more by choosing bar sizes suited to your hospital. Available in hospital-tested sizes: 1, 1¼ and 2½ oz.—also others. Write our laboratory at address below for technical and clinical information.

FROM THE INDUSTRIAL SOAP DIVISION OF ARMOUR AND COMPANY 1355 W. 31st Street, Chicago 9, Illinois

In vitro tests demonstrate Dial's extraordinary effectiveness

1. Ordinary toilet soap left this heavy growth of Staphylococcus aureus.

2. A widely-used antiseptic soap showed little inhibition of Staphylococcus aureus.

3. Dial soap completely inhibited Staphylococcus aureus.

For additional information, use postcard facing back cover.

the Ames idea: through simpler diagnostics... standardized results... manpower savings

There is no panacea for those universal hospital problems—rising costs and shortage of skilled help. But for many hospitals, a step in the right direction has been adoption of the AMES idea: the simpler the procedure, the less chance for costly error in execution and interpretation.

With this idea in mind, AMES through research has pioneered and perfected a growing line of *standardized* diagnostic products. The most rigorous *quality control* during every phase of production assures the *uniformity* and *reproducibility* of results that hospitals require.

In routine urinalysis, AMES Reagent Tablets are so simple to use that untrained as well as trained personnel obtain the same dependable, standardized results. The newer AMES Diagnostics are based on an even easier "dip-and-read" technique. And from one to three determinations can be made with one reagent strip.

Since there is no preparation of solutions or clean-up afterward, and these tests are actually performed in seconds, skilled technicians are freed for more demanding tasks.

Your AMES representative will welcome an opportunity to explain how AMES Diagnostics can achieve standardized results and save time and money in your hospital.

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

REAGENT TABLETS: ACETEST® · ALBUTEST® · BUMINTEST® · CLINITEST® · HEMATEST® · ICTOTEST® · OCCULTEST®

REAGENT STRIPS: ALBUSTIX® · CLINISTIX® · COMBISTIX® · KETOSTIX® · PHENISTIX™ · URISTIX®

Cheerful colors in nurses' and interns' quarters help build morale.

Lobbies and entry ways need friendly, encouraging colors.

Libraries require cool, quiet colors that aid concentration.

Stimulating hues at nurses' stations promote alertness.

Pittsburgh COLOR DYNAMICS® improves efficiency and morale of hospital staffs three important ways

Increasing recognition by hospital authorities of the therapeutic values of Pittsburgh COLOR DYNAMICS is transforming many impersonal establishments into cheerful, attractive ones.

• **This modern system of painting** is based upon the scientific knowledge of human reactions to the energy which colors possess. Experience in hundreds of hospitals demonstrates COLOR DYNAMICS makes it easy to choose colors that improve morale and efficiency these important ways:

1. Relieve eyestrain and nervous tension of surgeons in operating rooms.
2. Improve efficiency and alertness of nurses on duty.
3. Enhance comfort and morale of resident medical and nursing staffs.

• **Cheerful, comfortable environment** is also provided for patients. This soothes and encourages them, helps to speed their convalescence.

• **Why not use COLOR DYNAMICS** next time you paint? It can help you make your hospital a friendlier, more pleasant place. And you get all these benefits at no greater cost than normal maintenance painting.

• Send for free copy of booklet which explains what COLOR DYNAMICS is and how it can be applied. If you wish, we'll also gladly prepare a detailed color plan of your hospital, without cost or obligation.

Pittsburgh Plate Glass Co.,
Paint Div., Dept. MH-41,
Pittsburgh 22, Pa.

☐ Please send me a FREE copy of "COLOR DYNAMICS."

☐ Please have your representative call for a Color Dynamics Survey of our property without obligation on our part.

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PITTSBURGH PLATE GLASS COMPANY

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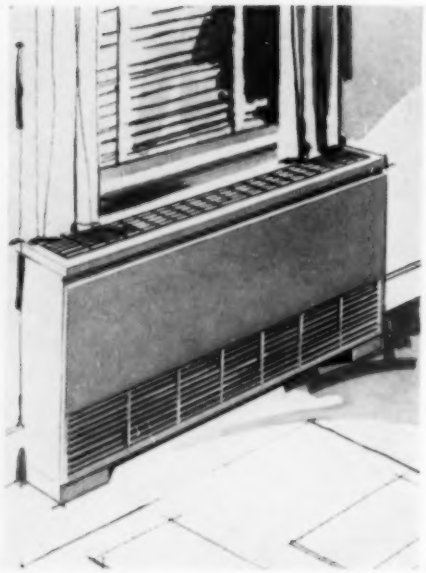


New Carrier Weathermaster Unit comes complete with self-contained control that improves performance, eliminates water valve problems, reduces installation cost. It automatically maintains room temperature at level dialed by room occupant.

This Carrier air conditioning development solves hospital maintenance problems

Here's a technical breakthrough in air conditioning of special significance to all who are concerned with hospital management. Carrier engineers have perfected a means of using the well-known and extremely simple air bypass principle to achieve automatic capacity control of high-velocity induction units.

Air bypass replaces the mechanically more complicated regulation of water flow through the coil. This not only completely eliminates costly water valve maintenance problems, it also provides these additional benefits:

Better control—quicker, more accurate response

Silent action—no water surge or gurgle

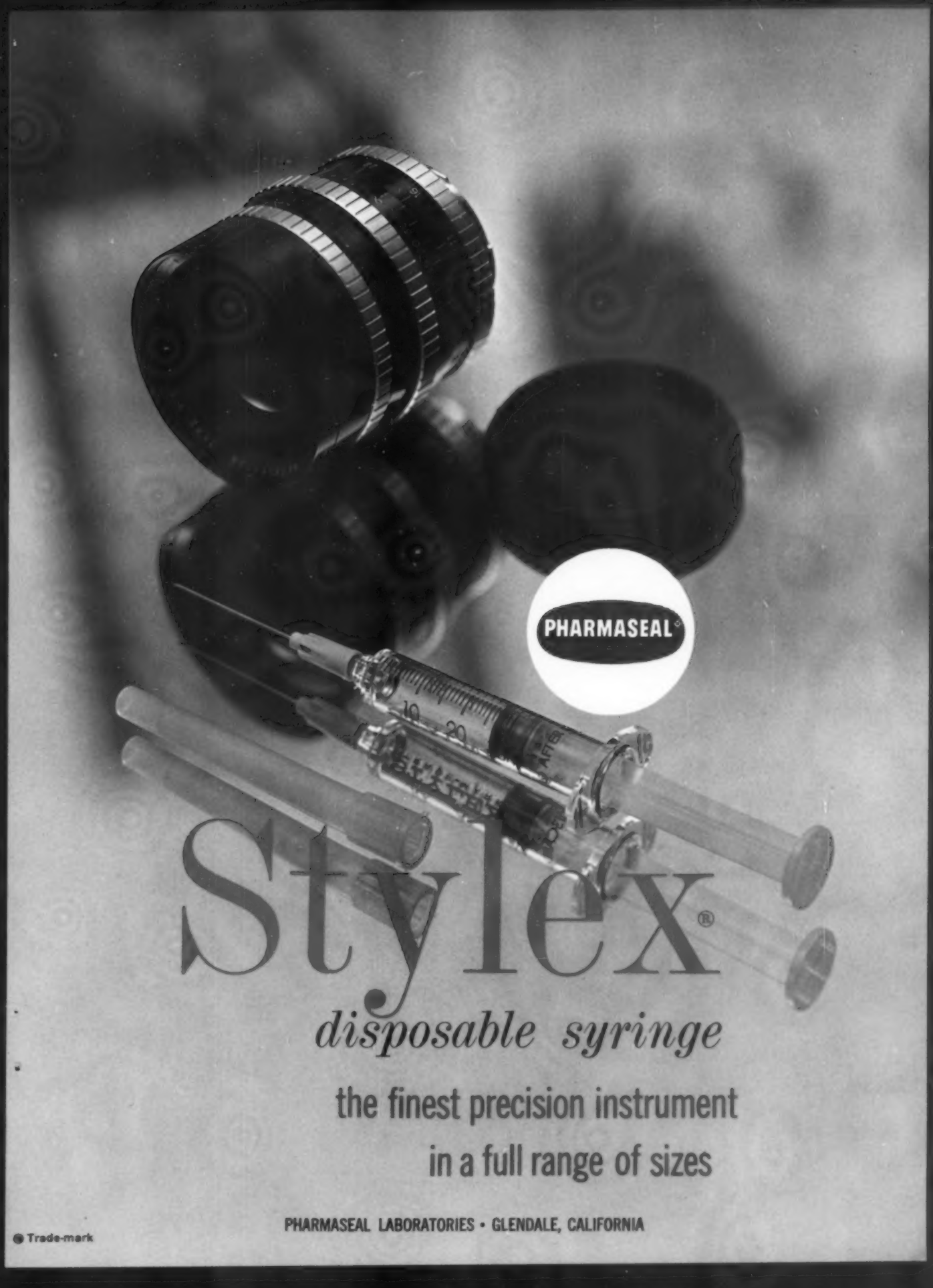
Simplified installation—no pneumatic connections
—no water control valves
—no service valves at unit

The Carrier Bypass Weathermaster* Units deliver only conditioned outside air—there is no recirculation of air between rooms. And where maximum filtering is desired, a chemically treated filter is available in lieu of a lint screen.

A Carrier representative will be glad to present the facts about the 36R Bypass Units to your architect and consulting engineer. Write Carrier Air Conditioning Company, Syracuse 1, New York. In Canada: Carrier Air Conditioning Ltd., Toronto.

**Reg. U. S. Pat. Off.*

Carrier Air Conditioning Company


PHARMASEAL®
stylex®
disposable syringe
the finest precision instrument
in a full range of sizes
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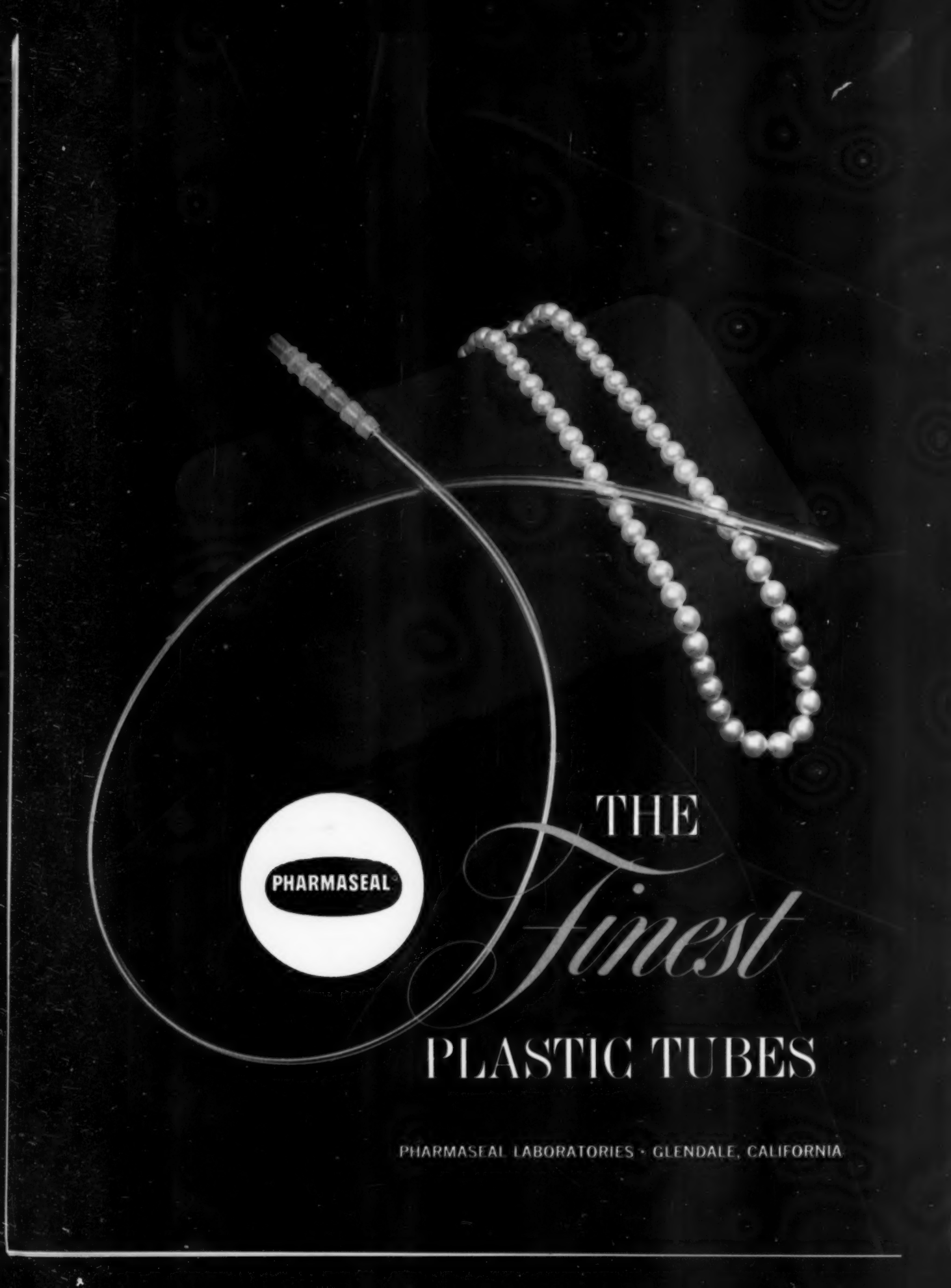
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THE
Finest
PLASTIC TUBES
PHARMASEAL LABORATORIES · GLENDALE, CALIFORNIA

Which petri dish costs the least?

When you use a dish just once, the cost is set, can never get lower. When you use PYREX® petri dishes, the cost per use dwindles. The more you use one, the more you save.

Take the three PYREX dishes up there. One is fresh from the stockroom, just going to work. The other two have been through the cleaning and sterilization mill more than 20 times.

All three are clear, unclouded, uncrazed, unscratched. These factors make PYREX petri dishes lowest in cost:

Long service life—in laboratory tests, we've run our dishes through normal-use cycles 24 times with no visible change.

Much less breakage—PYREX petri dishes have a rugged construction which makes them far more durable.

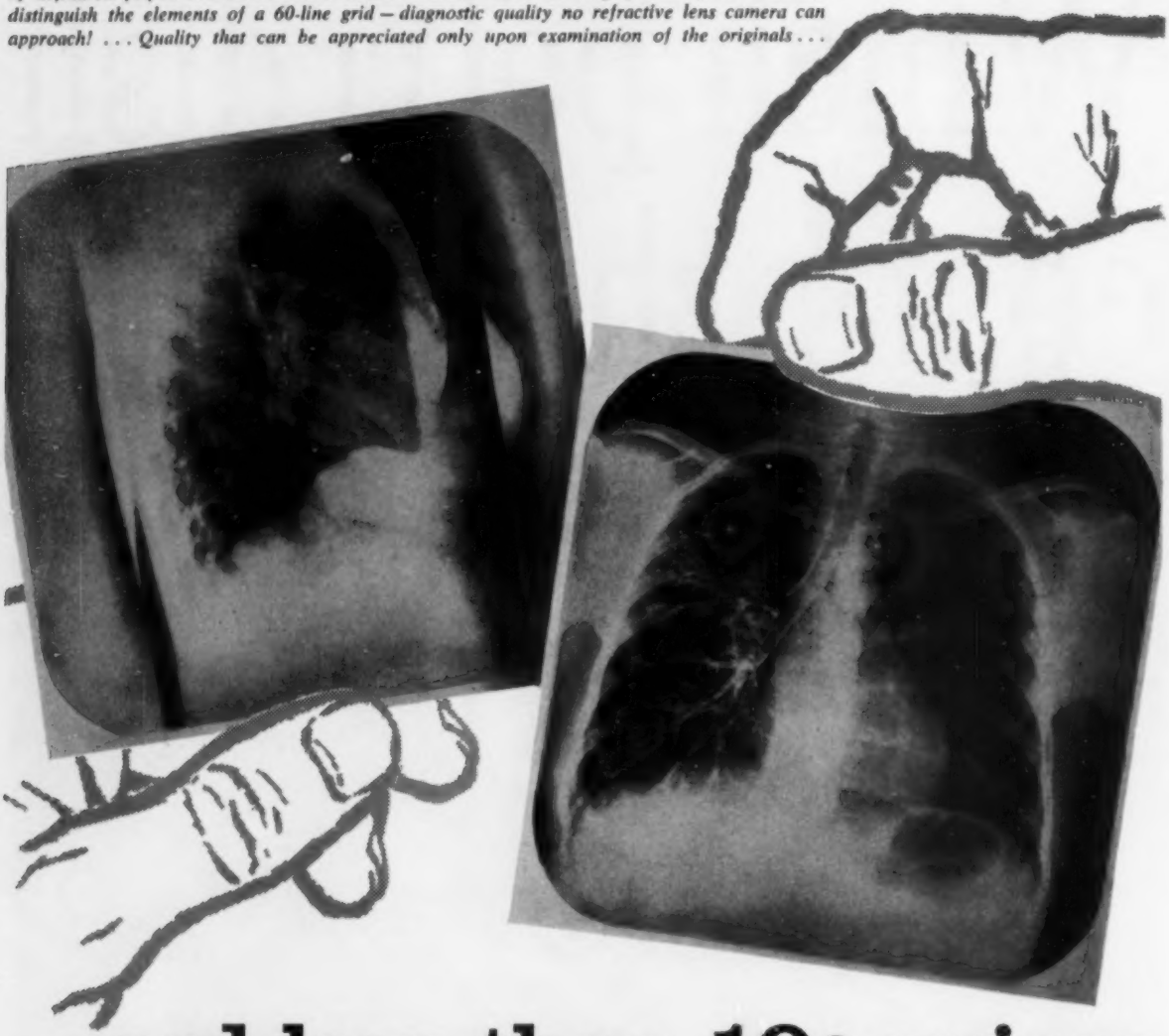
Plus the value features of special designs, such as our quadrant dishes and the ones with LIFETIME RED grids that last the life of the dish.

Your PYREX labware catalog LG-2 and your laboratory supply dealer can help you pinpoint other values that hold costs down when you use PYREX petri dishes. For your free copy of LG-2, please write.

CORNING GLASS WORKS
3804 Crystal Street, Corning, New York
CORNING MEANS RESEARCH IN GLASS

PYREX® laboratory ware ... *the tested tool of modern research*

THESE ARE FULL-SIZE REPRODUCTIONS *of Odelca 4" x 4" radiographs. Their superlative standard of definition fulfills the Chantraine condition – under six times magnification you can easily distinguish the elements of a 60-line grid – diagnostic quality no refractive lens camera can approach! . . . Quality that can be appreciated only upon examination of the originals . . .*



. . . and less than 10c apiece

With an Odelca Photo-Fluorographic Camera, you can now afford extensive X-Ray programs – admission chests, mass surveys, cerebral angiography, angiocardiography – without sacrificing diagnostic quality! Here's why . . .

The Odelca PF Camera Speeds Up the X-Ray Process

Up to 100 exposures, automatically at one loading, at speeds up to 6 frames/sec.!

The Odelca PF Camera Cuts the Cost of Film

An average of less than 10¢ per exposure for the 100mm (4" x 4"), only 3¢ for the 70mm. Pays for itself in film savings alone after only 10,000 exposures – in about one year in most medium-sized hospitals!

The Odelca PF Camera Cuts Processing Costs

Twelve 4" x 4" negatives or twenty-four 70mm negatives for the cost of one full-sized radiograph, figuring the cost of film and chemicals alone!

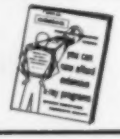
Over 1200 Odelca PF Cameras sold this year throughout the world – Thirty Times as many as all other makes combined!

The Odelca PF Camera Reduces Storage and Handling Requirements

20,000 4" x 4" pictures weigh 12 tons less than the same number of full-sized radiographs!

Revolutionary in concept. 4-5 times faster than refractive lens cameras. Reduces radiation exposure 75-80%. Exceptionally super-speed Bouwers' concentric mirror optical system.

Interested? Get the whole story. Ask for this informative 8-page brochure. Contact your local X-Ray supply house or –



odelca

6 BURNS AVENUE • HICKSVILLE, N.Y.

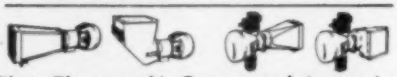
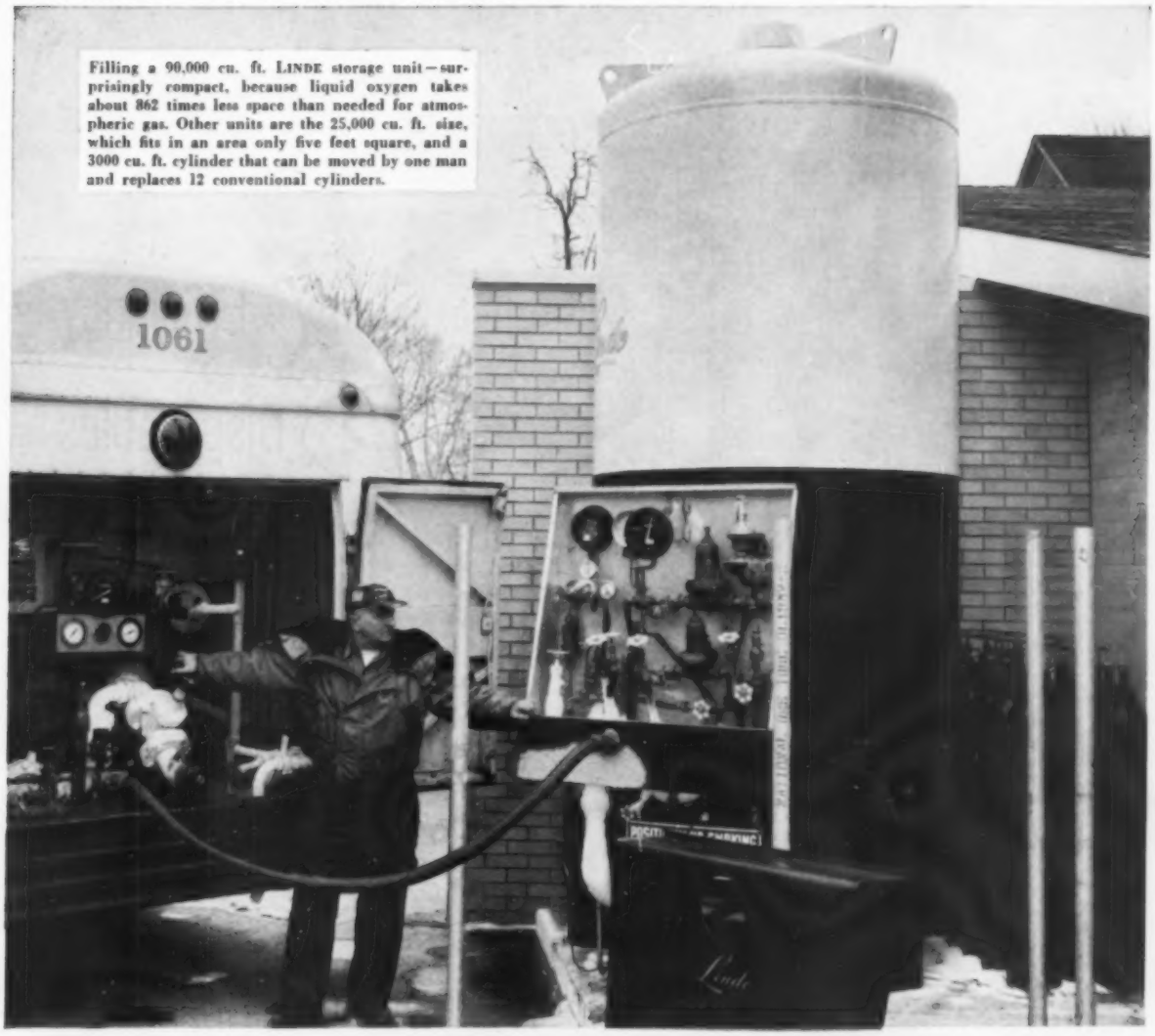


Photo-Fluorographic Cameras and Accessories



Filling a 90,000 cu. ft. LINDE storage unit—surprisingly compact, because liquid oxygen takes about 862 times less space than needed for atmospheric gas. Other units are the 25,000 cu. ft. size, which fits in an area only five feet square, and a 3000 cu. ft. cylinder that can be moved by one man and replaces 12 conventional cylinders.

YOU'VE GOT TO BE SURE ABOUT OXYGEN

With hospital oxygen, you've got to be sure that it's produced to U. S. P. standards . . . that it's properly stored and handled . . .

And you've got to be sure that it's there when you need it.

You don't face problems like these when you have a LINDE liquid oxygen system installed. Any general hospital from 25 beds up can have liquid oxygen. Experienced LINDE representatives are ready to help in selecting and installing the equipment you need. You will find that liquid oxygen takes only a fraction of the storage space required for gas. Highly qualified personnel supervise its production all along the line. And deliveries are regular and dependable, wherever your hospital may be located in the United States.

Take advantage of more than 50 years of LINDE experience in the oxygen business. Call your nearest LINDE representative or distributor. Or write Linde Company, Division of Union Carbide Corporation, 30 East 42nd Street, New York 17, N. Y. *In Canada:* Linde Company, Division of Union Carbide Canada Limited, Toronto.

Linde UNION CARBIDE

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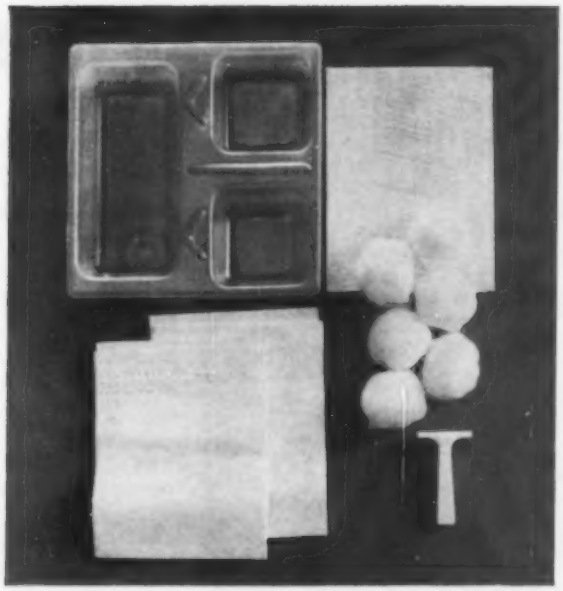


DISPOSABLE PREP SET • Multi-Cupped Tray • Razor (with blade) • 2 Absorbent Towels • 6 Cotton Balls • Plastic-Coated Towel • Plastic Cover

STERILE DISPOSABLE RUBBER CATHETER • New low price! • All purpose—combines the desirable features of the Nelaton and Robinson style catheters • May also be used as aspirating catheter

STERILE DISPOSABLE CATHETERIZATION SET • New All-Purpose **Rubber** Catheter for use where 14 or 16 French is desired (optional) • Multi-Cupped Tray • Specimen Container • Lubricant • 8 Cotton Balls • Pickup Clip • Plastic Gloves • Plastic-Coated Towel • Plastic Cover

For complete information please write on your Professional or Institutional letterhead to:

DAVOL RUBBER COMPANY PROVIDENCE 2, RHODE ISLAND

The superior performance of DennisonWraps with regard to

Sterile Techniques in Autoclaving

***These frank questions and answers* will help you evaluate reusable double-creped paper DennisonWraps. Maybe you have asked some of these questions yourself in discussing your own autoclaving procedures.**

Q. *You say inspecting DennisonWraps is easier and safer than inspecting muslin, yet we have no trouble inspecting muslin in ordinary daylight. Why do you claim that ours is a hazardous practice?*

A. Your own tests will prove it! Take 25 muslin wrappers that have passed daylight inspection. Examine them carefully on both sides with lights above and below them. Look for breaks in fibers due to deterioration caused by repeated laundering and autoclaving. In at least one of the 25, you're sure to find broken fibers. At each break, there is only one thickness of muslin. This does not meet sterilizing requirements. With DennisonWraps, you're always safe because breaks are immediately evident.

Q. *Why do you talk of the floppiness of muslin as if it were a bad feature?*

A. Nursing arts instructors tell us that the average graduate nurse is so accustomed to handling the limp, floppy folds of muslin that she forgets her student days. She forgets the hours of classroom instruction required to teach her how to unwrap packages so that neither the muslin nor its contents are contaminated. The disadvantage of muslin's limpness is apparent when a package is unwrapped on a flat surface such as a table top. If the muslin folds flop down on the surface, two things happen. Bacteria on the surface are dislodged, and air currents are set up. The airborne bacteria can be swirled directly into the contents of the package. This is why floppiness is a bad feature.

Q. *Why are DennisonWraps safer than muslin as far as the unwrapping technique is concerned?*

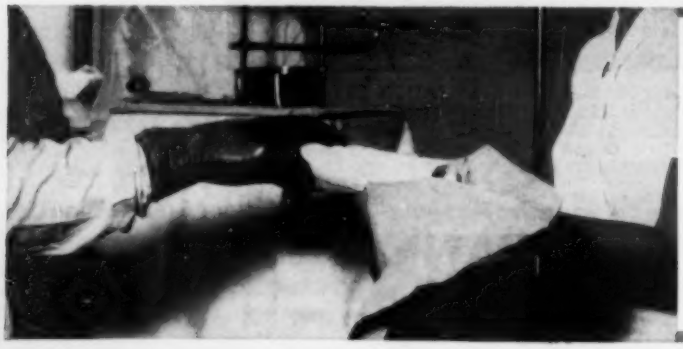
A. In contrast to the limpness of muslin, double-creped DennisonWraps have a sturdier body. So, they act more predictably when unfolded. This gives the young student less of a problem in learning to control the folds. Moreover, when a package wrapped in DennisonWraps is opened, the shape-conforming paper remains cupped, providing a protective wall around the contents.

Q. *You claim rapid and effective penetration of steam through DennisonWraps. How is this tested?*

A. In two ways. First, by Densometer porosity tests which prove that DennisonWraps freely pass air under pressures encountered in autoclaving; but, not at atmospheric pressure. Secondly, by thermocouples embedded in wrapped packages in the autoclave and attached to an external potentiometer. The time required for the center of the package to reach sterilizing temperature of 121°C is the measure of effective steam penetration. Comparative tests using one layer of DennisonWraps and two layers of muslin show that steam penetration is 5 minutes faster with DennisonWraps. Laboratory reports of these tests are available on request.

Q. *What's the most practical way to introduce DennisonWraps into our hospital?*

A. Get a free hospital evaluation kit. It contains test quantities of DennisonWraps in precut sheets; glove wicks, envelopes and cases; three clinical reports which prove that DennisonWraps will increase the safety, efficiency and economy of your autoclaving operations. Ask your local hospital supply house . . . or address your request to Dennison Manufacturing Co., Dept. R-9 Framingham, Mass.



FOR SAFETY'S SAKE
insist on reusable

DennisonWraps

. . . identified by their exclusive hygienic imprint

on the pathogenesis of pyelonephritis:

"An inflammatory reaction here [renal papillae] may produce sudden rapid impairment of renal function. One duct of Bellini probably drains more than 5000 nephrons. It is easy to see why a small abscess or edema in this area may occlude a portion of the papilla or the collecting ducts and may produce a functional impairment far in excess of that encountered in much larger lesions in the cortex."[1]

The "exquisite sensitivity"[2] of the medulla to infection (as compared with the cortex), highlights the importance of obstruction to the urine flow in the pathogenesis of pyelonephritis. "There is good cause to support the belief that many, perhaps most, cases of human pyelonephritis are the result of infection which reaches the kidney from the lower urinary tract."[3]

to eradicate the pathogens no matter the pathway

FURADANTIN®

brand of nitrofurantoin

High urinary concentration • Glomerular filtration plus tubular excretion • Rapid antibacterial action • Broad bactericidal spectrum • Free from resistance problems • Well tolerated—even after prolonged use • No cross resistance or cross sensitization with other drugs

Average Furadantin Adult Dosage: 100 mg. tablet q.i.d. with meals and with food or milk on retiring. *Supplied:* Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. 102:32, 1958. 2. Freedman, L. R., and Beeson, P. B.: Yale J. Biol. & Med. 30:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. 30:341, 1958.

NITROFURANS—a *unique* class of antimicrobials

EATON LABORATORIES, DIVISION OF THE NORWICH PHARMACAL COMPANY, NORWICH, N. Y.

Can you afford to give away medication?

As hospital costs mount, it is becoming increasingly evident that the beneficiaries of hospital services—the patients—must assume their fair share of the costs incurred. For this to occur, the hospitals must be able to account scrupulously, either to the patients or to the various prepaid hospital plans, for all services and medication.

Old-style injections too complicated

Because accounting and billing for medication withdrawn from multidose vials has been so difficult and time consuming, many hospitals have virtually been forced to write off the cost of common injectables or, at best, to estimate them. Yet it is clear that few hospitals can afford to give away medication or to rely on estimates, which are often unacceptable by the prepaid plans.

TUBEX lets you charge fairly

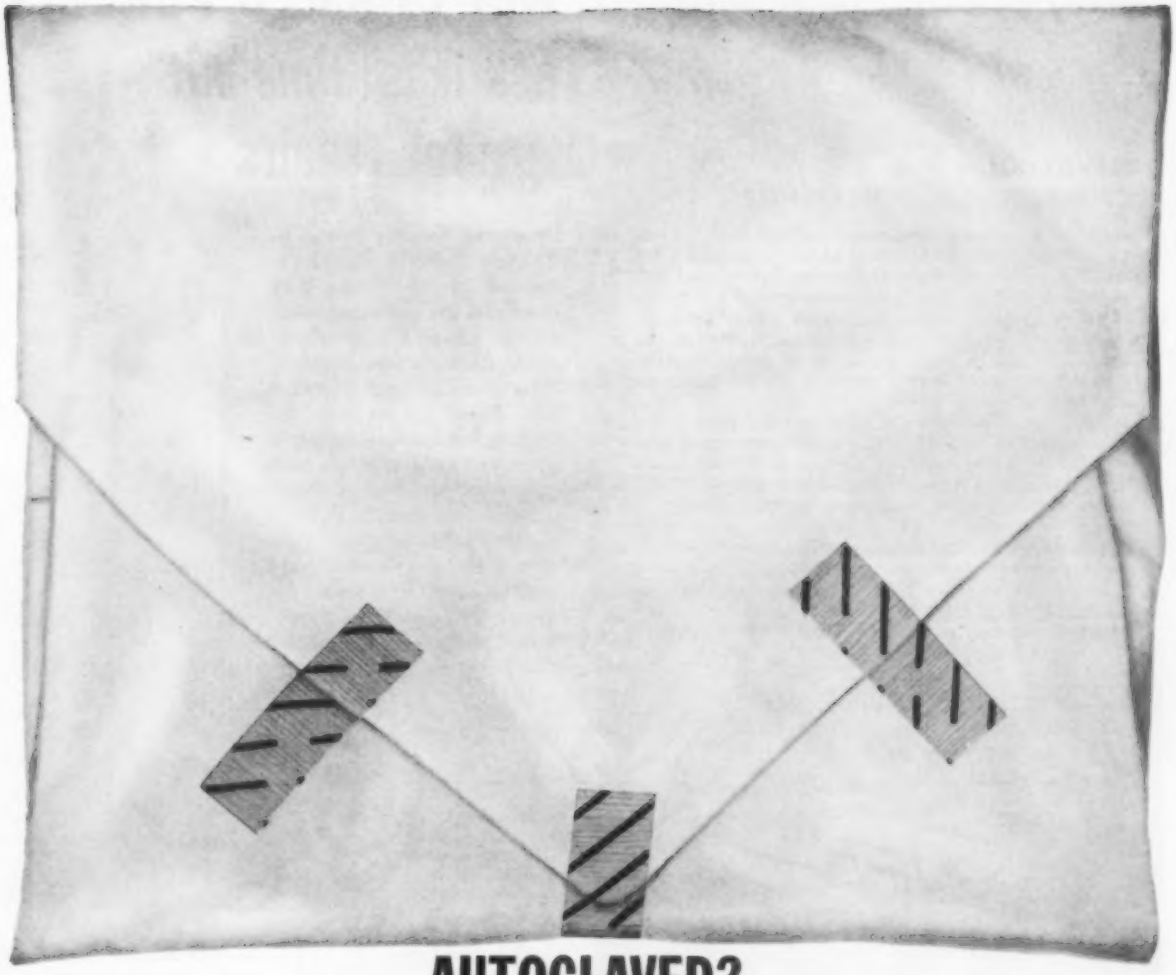
The TUBEX system provides individual, unitized doses of medication in tamper-proof cartridge form. It's an easy matter to keep track of medication dispensed and administered. ***You know just what each patient received, and precisely how much. And you can charge accordingly, with unassailable fairness.***

The need to charge accurately and as completely as possible is being met by the TUBEX system in more and more hospitals across the nation. Typical of the accolades the system has won is the following, excerpted from *The Bulletin of the Parenteral Drug Association:*

The charge made to the patient should include all services rendered. When most of these services are built into the product by the supplier—guaranteed identified contents and dosage, guaranteed sterility, plus simplified record keeping and control—and included in a single purchase price paid to the supplier, there is no problem in justifying the charge to the patient. It is a charge that can easily be backed up by records, and it does not strain the credulity of any investigator.—Crohn, L.B.: The Bulletin of the Parenteral Drug Association, p. 23, March-April, 1960.

If you want to learn more

Your Wyeth Territory Manager will be glad to give you all the details about the TUBEX system. Or, write to Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.



AUTOCLAVED? YOU CAN BE SURE!

There is no doubt when you seal bundles and containers with "SCOTCH" Brand Autoclave Tape No. 222. Dark lines appear on the tape only after exposure to correct levels of heat and moisture in an autoclave. Any other heat and/or moisture exposure cannot activate the tape. "SCOTCH" Autoclave Tape holds fast before, during and after autoclaving . . . applies easily . . . sticks at a touch to paper, cloth, glass, metal . . . leaves no residue. "SCOTCH" Autoclave Tape is faster to use than pins, string, cotton plugs, and may be easily marked with pen, pencil or typewriter.

New! For gas sterilizers!

Now, secure sealing and positive identification of gas sterilized bundles are made possible with new "SCOTCH"Brand Ethylene Oxide Sterilizer Tape No. 224. This tape offers the same assurance of proper exposure that "SCOTCH" Brand Tape No. 222 does in steam autoclaves. For complete details, contact your surgical supply dealer, or write 3M Company, St. Paul 6, Minnesota.

(Note: Each of these tapes is designed for a specific purpose. The Autoclave Tape will not function in a gas sterilizer; nor will the Ethylene Oxide Tape function in a steam autoclave. Nothing on the outside of an autoclaved or gas-sterilized item, of course, can guarantee sterility of contents.)

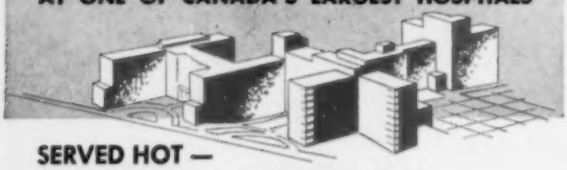
"SCOTCH"® BRAND HOSPITAL AUTOCLAVE TAPE NO. 222

"SCOTCH" is a registered trademark of 3M Co.

MINNESOTA MINING AND MANUFACTURING COMPANY 3M

...WHERE RESEARCH IS THE KEY TO TOMORROW

5700 MEALS A DAY
AT ONE OF CANADA'S LARGEST HOSPITALS

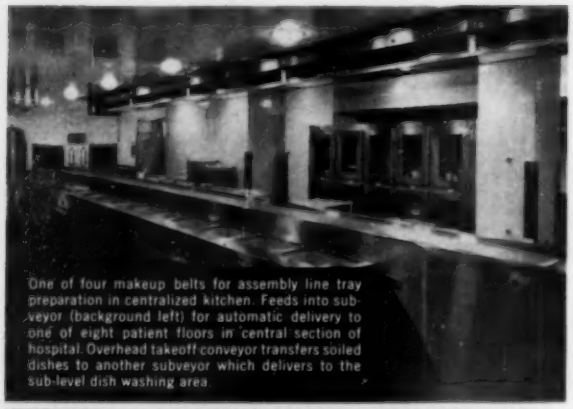


SERVED HOT — ON SCHEDULE — WITH LESS HELP

A sprawling miracle of modern medical care, L'Hospital Notre-Dame, Montreal serves a record 5700 meals a day—on schedule and piping hot. A vital link in this important phase of patient care is a network of Olson Conveyors and Subveyors which automatically speed meals from a centralized kitchen to the farthest wings of the eight-story hospital. Another system handles soiled dish return to the sub-basement dishwashing room.

Four assembly lines for tray makeup feed into a combination of takeoff conveyors and connecting subveyors, depending on the wing and floor destination. This eliminates all tray handling from assembly lines to patient floors—also elevator tie-ups at meal time and the excess noise of moving carts. Further, it facilitates pin-point scheduling for more efficient use of nursing and supervisory time.

Learn how an Olson System can help your hospital or institution cut labor costs and speed service through assembly line tray makeup and mechanized dish flow. Request Bulletin 1502.



One of four makeup belts for assembly line tray preparation in centralized kitchen. Feeds into subveyor (background left) for automatic delivery to one of eight patient floors in central section of hospital. Overhead takeoff conveyor transfers soiled dishes to another subveyor which delivers to the sub-level dish washing area.

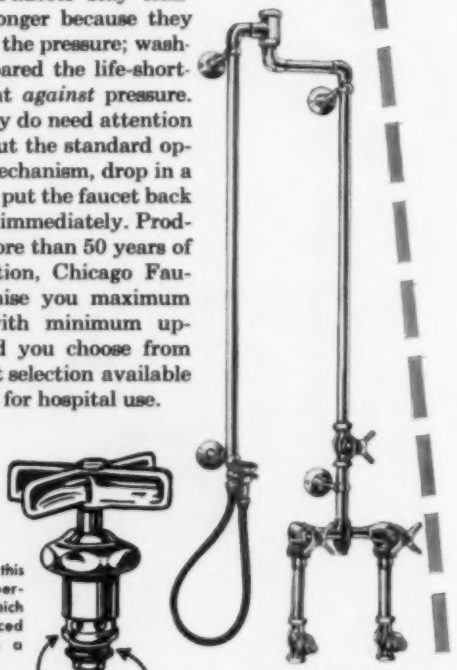
Portion of another network of overhead takeoff conveyors and subveyors bringing trays of soiled dishes from all wings and floors to sub-level dishwashing room.

OLSON CONVEYORS

Manufactured By **SAMUEL OLSON MFG. CO., INC.**
2423 Bloomingdale Ave. • Chicago 47, Illinois
DIVISION OF CHERRY-BURRELL CORPORATION

Why Chicago Faucets ask less "*time-out*" for repairs

Operating records prove it. Chicago Faucets stay leak-free far longer because they close *with* the pressure; washers are spared the life-shortening fight *against* pressure. When they do need attention just lift out the standard operating mechanism, drop in a spare and put the faucet back in service immediately. Products of more than 50 years of specialization, Chicago Faucets promise you maximum service with minimum upkeep. And you choose from the largest selection available of faucets for hospital use.



The secret's in this standard operating unit which can be replaced as easily as a light bulb.

No. 904 Bed Pan Flusher with integral vacuum breaker. Others with concealed piping, different spouts and sprays, etc.

No. 631 Wrist-Operated Wash-up Fixture. Also pedal- and leg-operated types, different spouts, etc.

The Chicago Faucet Co.
2712 N. Pulaski Rd., Chicago 39, Ill.

HERE'S HELP—
If you buy or specify faucets for hospital use write for complete catalog . . . or new Sketch Book of engineering data on special faucets.

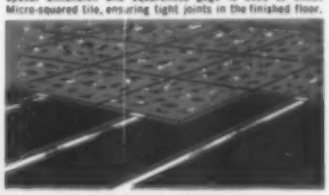
CHICAGO FAUCETS®
Last As Long As the Building

Distributed through the plumbing trade exclusively

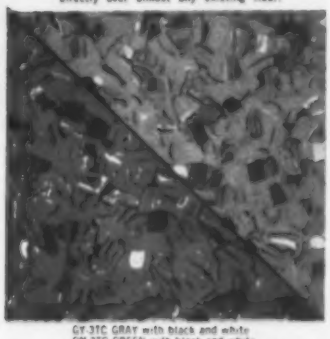
VPI CONDUCTILE®
SOLID VINYL FLOORING REDUCES EXPLOSION DANGERS!

VPI CONDUCTILE floor installation being tested for conductivity by a factory representative.

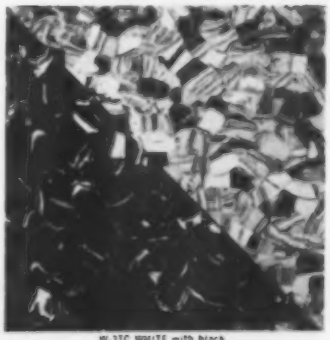
Special dimension and squareness gage is used to check Micro-squared tile, ensuring tight joints in the finished floor.



Can be installed overnight in most cases, directly over almost any existing floor.



GY-3TC GRAY with black and white
GN-3TC GREEN with black and white



W-3TC WHITE with black
BK-3TC BLACK with white

ELIMINATES PRINCIPAL SOURCE OF EXPLOSIONS OF ANESTHETIC GASES

Keep electrostatic discharge at a minimum by installing VPI CONDUCTILE wherever anesthetic gases are used! VPI CONDUCTILE is especially engineered solid vinyl conductive flooring which dissipates electrostatic charges from persons wearing conductive shoes and from conductive equipment making electrical contact with the floor. VPI CONDUCTILE is guaranteed for 5 years to meet all the requirements of the National Fire Protection Ass'n and the National Bureau of Fire Underwriters, as described in their bulletin No. 56. The installation of VPI CONDUCTILE, together with other prescribed precautionary measures, is inexpensive insurance against the likelihood of calamity.

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. . . makers of prestige vinyl flooring – **CLASSIC MARBLE, VERAZZO, VINYLAST, TERRALAST, ULTRALAST** – for institutional and residential use

CONDUCTILE®
VPI

For additional information, use postcard facing back cover.

NO. 2 IN A SERIES

This is the second in a series of articles on High Vacuum Sterilization and how it brings greater safety and efficiency to hospital sterilization. Its author is Richard D. Castle, head of Research and Development, Wilmot Castle Company, Rochester, N.Y. Working with the Drayton Regulator & Instrument Co., Ltd., of England, Castle has developed the OrthoVac* High Vacuum Sterilizer. First models will be installed in U. S. hospitals this year.

The Essentials of HIGH VACUUM Sterilization

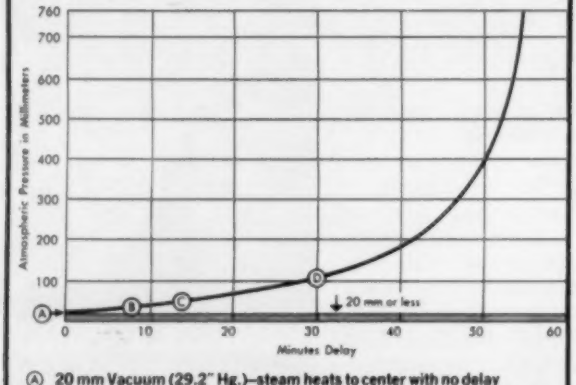
by Richard D. Castle

● The advent of High Vacuum Sterilization brings four major advantages to hospital "dry goods" sterilization. The first is *speed*. Using the High Vacuum System, a typical "dry goods" cycle is run in 15 minutes compared to conventional cycles of one to two hours. A second advantage is *safety*. With the drawing of a near-absolute vacuum, uniformity of temperature throughout the load is obtained within a predictable period. Common errors in packaging and loading are no longer critical. Sterilization becomes a mathematical certainty. Sterilizers may be *loaded to capacity*—an increase of approximately 25% for every existing "dry goods" sterilizer. Finally, there is greater *preservation of fabrics* with reduced exposure time.

● There are certain essentials to the practical operation of a High Vacuum System. Success depends on removal of *enough air* so there can be no variation in the time necessary for steam-air interchange. This requires a vacuum of less than 20mm Hg. abs. The Castle-Drayton OrthoVac System uses a high-efficiency *oil-seal vacuum pump* to draw such vacuum. Steam penetration and load heat-up are thereafter practically instantaneous. An oil-seal pump is used because it is fast and provides considerable reserve capacity in the critical range as a safety factor. On the other hand, water-seal pumps tend to drop in efficiency as they approach the critical range and are dependent on water supply temperature.

● The importance of adequate vacuum is shown in Chart 1., which indicates relationship of speed of heating and degree of vacuum obtained.

CHART NO. 1



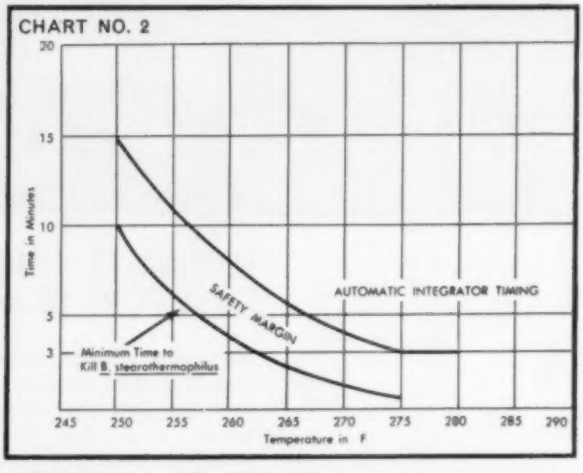
Ⓐ 20 mm Vacuum (29.2" Hg.)–steam heats to center with no delay
Ⓑ 40 mm Vacuum (28.4" Hg.)–steam heats to center after 8 minute delay
Ⓒ 60 mm Vacuum (27.6" Hg.)–steam heats to center after 15 minute delay
Ⓓ 100 mm Vacuum (26.0" Hg.)–steam heats to center after 30 minute delay

● For efficiency and safety, *the same degree of vacuum* must be drawn during each cycle. To guarantee this the OrthoVac System employs an exclusive *barometrically compensated absolute pressure switch*. This device safeguards the cycle by automatically compensating for height of the sterilizer above sea level and daily barometric pressure fluctuations. The need for manual adjustments to allow for critical changes in ambient pressure is eliminated.

● With the establishing of a near-absolute vacuum, it is possible, for the first time, to safely determine the time required for all parts of a load to reach killing temperature—regardless of size of load or manner of packaging.

● Once known, this permits use of the exclusive OrthoVac *Time-Temperature Integrator* in the control of the timing phase. Whatever temperature has been pre-selected at 250° F. or over, the Integrator automatically selects the exact time necessary for kill, based on established bacteriological law. The operator selects temperature only, leaving correct selection of exposure period to the sterilizer's automatic control system. Recording instruments monitor successful attainment of sterilizing conditions. Chance of human error in exposure settings is eliminated. Chart 2. shows how Integrator has been engineered to follow established bacterial kill time, while adding a built-in safety margin.

CHART NO. 2



● In operation, the Integrator automatically compensates for temperature variations due to rise or drop of steam pressure or other causes. Should temperature drop within the 275-250° F. range, the *exposure period is automatically extended for the time required at the lower temperature*. Other high vacuum systems rely on clock mechanisms which necessitate recycling of the entire timing phase when temperatures fall below the pre-set level. This not only lengthens total cycle time, but accelerates deterioration of fabrics and rubber.

● *First production models of the OrthoVac Sterilizer will be installed in hospitals this year. Based on Drayton's experience in England, the OrthoVac System has been developed as a control console to permit on-the-job conversion of many existing "downward displacement" sterilizers. The console design will allow hospitals to convert present sterilizers to the safer, more efficient High Vacuum System without spending the additional funds necessary to purchase a complete new sterilizer, or altering present sterilizer facilities to accommodate additional sterilizing equipment.*

For further information on OrthoVac write for Bulletin H-283.

WILMOT CASTLE COMPANY, 2004 E. Henrietta Rd., Rochester 18, New York

Subsidiary of Ritter Company Inc.

*Trademark Wilmot Castle Company

"Hospital Designed"

Maysteel Casework

"Reach Planned" for Nurses' Convenience

Keeping the nurses' work load in mind and designing equipment to minimize it is one of the fundamental requirements of Maysteel "Hospital Designed" Casework.

Reach planning is one of these work-saving, step-saving, fatigue-saving features. For instance, in the illustration above, you notice that cabinet door pulls and drawer handles can be reached without the effort of squatting, bending, stretching or turning. Counter and working surfaces are built to average-height for minimum fatigue, and greater convenience. The highest shelves are brought down to easy reach from floor level with no loss of storage area.

Maysteel Keeps the Work-Load in Mind and Designs Equipment to Minimize It

And these are only a few of many functional work-flow advantages you'll find in Maysteel Casework. They'll show basic reasons why Maysteel "Hospital Designed" Casework provides your best investment for year upon year of trouble-free service. Return the coupon for complete details.

MAYSTEEL PRODUCTS, INC.
742 N. Plankinton Avenue, Milwaukee 3, Wisconsin

☐ Send New Maysteel Catalog and Planning Guide
☐ Give us name of nearest Maysteel representative

Name .....
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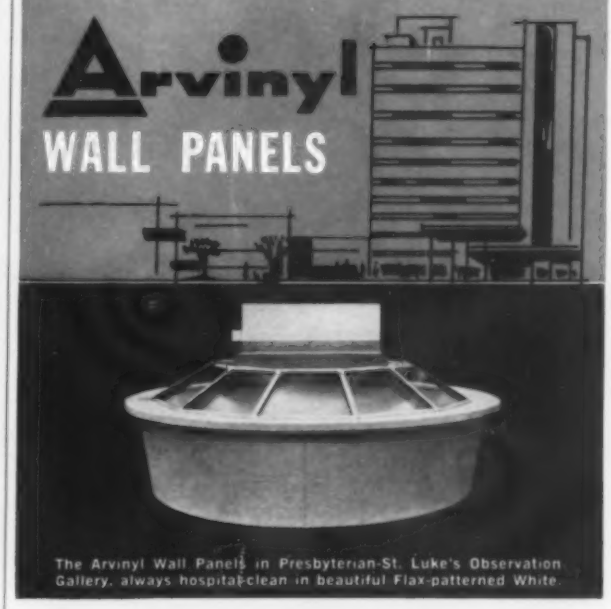
City ..... State .....
Attn. of .....

unique application!

Arvinyl WALL PANELS



The Arvinyl Wall Panels in Presbyterian-St. Luke's Observation Gallery, always hospital-clean in beautiful Flax-patterned White.

give Presbyterian-St. Luke's observation gallery domes "scuff-proof" beauty

Newfound applications for the strength and durability of Arvinyl Wall Panels are being created more and more throughout the country. The new Presbyterian-St. Luke's Hospital in Chicago, for example, chose Arvinyl Wall Panels for the sides of twin domes in its observation gallery above the operating theater. These domes get plenty of wear, but with Arvinyl Wall Panels maintenance has been eliminated from the very start. No patching ever, because of their tremendous, proven durability in resisting impact or abrasion. No painting, either . . . these washable panels are unaffected by ink, lipstick, alcohol, boiling water and other liquids. The non-absorbing surface is easier to keep hygienically clean.

As new walls or over old walls, Arvinyl Wall Panels actually pay for themselves in maintenance savings over the years, and give any interior permanent beauty.

Whether you are planning an expansion, remodeling or new building project it will pay you to consider Wall Panels made of Arvinyl, the exclusive vinyl/metal laminate. Available in a wide variety of colors, textures and patterns. Call or write Arvin for complete information and the name of your nearest distributor.

Arvin Architectural Products Division
ARVIN INDUSTRIES, INC., COLUMBUS, INDIANA

BEHIND THE IRON CURTAIN

Ever wonder what happens to gift parcels of western "brand" drugs sent to families behind the Iron Curtain? Well, as reported from one of the satellite countries, if the recipient wishes to use it, he can. If not, the government buys the drugs . . . supposedly as a gesture of good will to the family. ■ But actually, the western brands are bought and resold through stores to government leaders and others who can afford the price. They are sold even though the government manufactures a generic product of each type for **free** distribution. ■ Strange? Or not so strange. When it comes to a matter of life, health and disability, **trust** becomes a critical factor to anyone, anywhere – trust in the knowledge of the physician . . . trust in a known drug. And apparently even in the "land of generics" more trust is placed in the brand name system of a free economy. They acknowledge what we hold to be fundamental: **In order to exist, the brand name manufacturer must do his job better...select raw materials with greater care...exercise greater control in compounding and testing...meet more than average or acceptable specifications...know more about possible pitfalls of production through original research.** ■ These are the factors built into a reputable brand name . . . ultimately the only assurance to physician and patient of maximum drug performance.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

For fewer transfusions . . .
clearer operative field . . .
less postoperative nursing . . .

Adrenosem®*

SALICYLATE

(Brand of carbazochrome salicylate)

The patient, surgical team and nursing staff all benefit when Adrenosem is part of the preoperative routine because it helps maintain capillary integrity.

Adrenosem decreases excessive capillary permeability and promotes retraction of severed capillary ends, thus diminishing excessive bleeding. This conserves the patient's own blood so less is needed from the blood bank. Since the operative field is clearer, surgical procedures are facilitated and operating time shortened. In the postoperative period, reduction in seepage and oozing means fewer calls on the nursing staff.

At recommended dosage levels there are no contraindications. The safety and effectiveness of Adrenosem have been proved in over seven years' use . . . fifteen million doses . . . thousands of hospitals.

*U.S. Pat. Nos. 2981650; 2906294

SUPPLIED: *For oral administration* **—Tablets:** 1 mg. (s.c. orange), bottles of 50, and 2.5 mg. (s.c. yellow), bottles of 50. **Syrup:** 2.5 mg. per 5 cc. (1 tsp.), bottles of 4 oz.

For I.M. injection—**Ampuls:** 5 mg., 1 cc., packages of 5 and 100; 10 mg., 2 cc., packages of 5.

Write for detailed literature and dosage information.

THE S. E. MASSENGILL COMPANY

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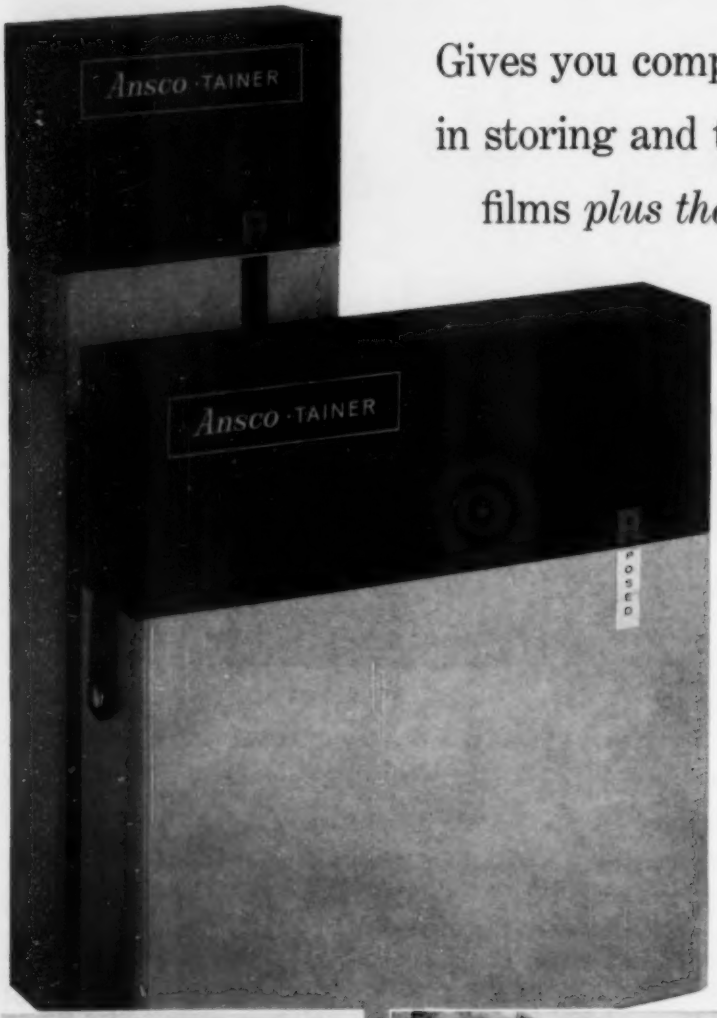
NEW ANSCO-TAINER!



Gives you complete safety in storing and transporting X-ray films *plus these important extras:*

1. Lightweight—strength without bulk.

2. Light-tight—completely light sealed.

3. Superior construction—protects film against artifacts.

4. Durable—Long-wearing plastic finish resistant to stains.

5. Perfect size—carries just the right amount of film needed to do the job . . . will hold a 75 sheet interleaved or 150 sheet non-interleaved Pouchpak from a Superpak or Bulkpak® carton.

6. Economy—costs far less than expensive suitcase containers.

7. Easier darkroom handling—cover opens and closes with ease in dark.

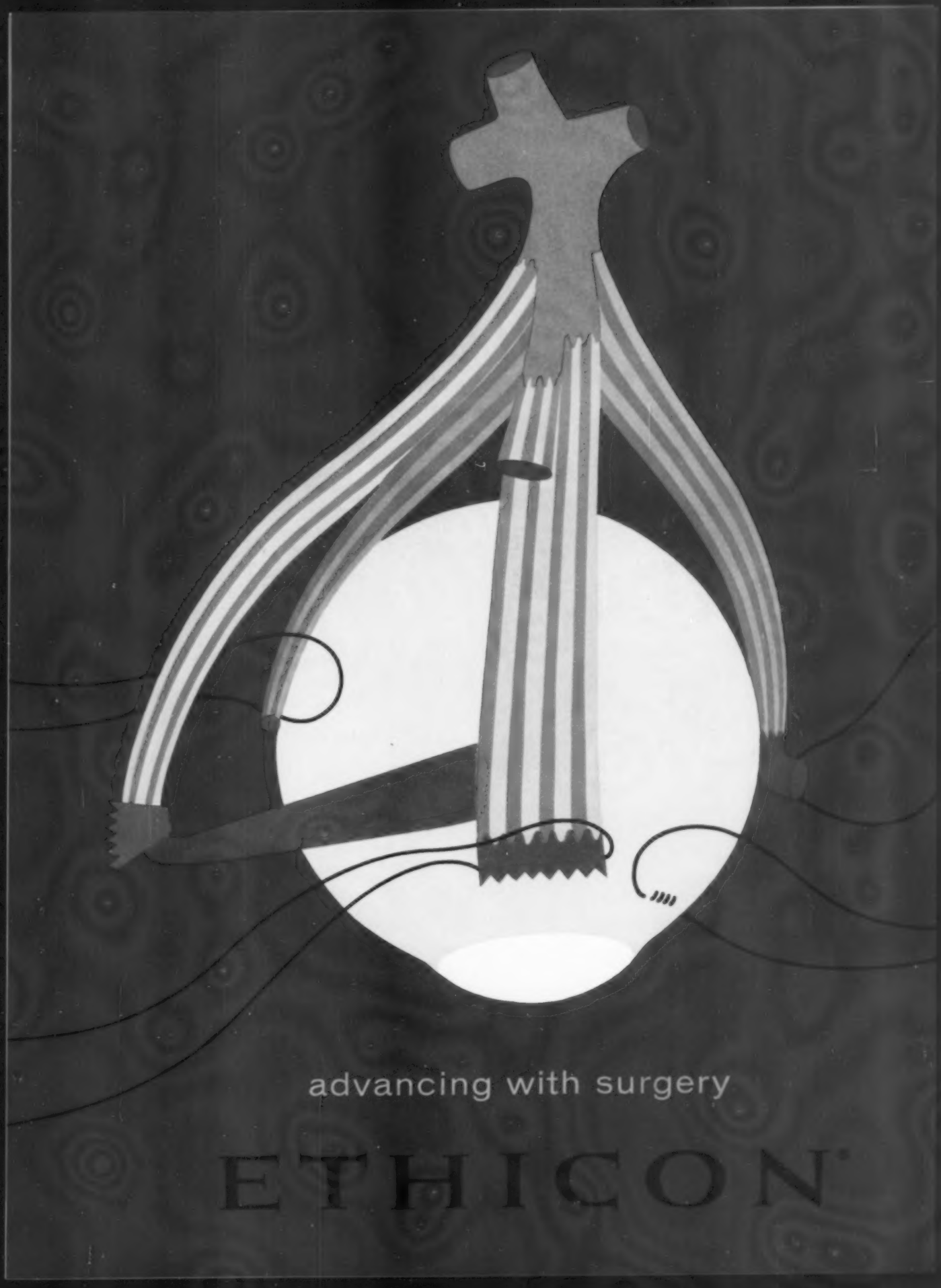
But the new ANSCO-TAINER has to be seen to be appreciated! Handsome, versatile, the perfect darkroom-to-equipment-area X-ray film carrier. Pack it, pick it up and go . . . no bulky cases when bulk is unnecessary. As protective and as safe for your film, as the darkroom itself! Ansco, Binghamton, New York, A Division of General Aniline & Film Corporation.

Versatile—the Ansco-Tainer is the right size for most jobs. Holds a complete Pouchpak from a Superpak or Bulkpak carton.

A few sheets or a single sheet . . . complete safety for exposed or unexposed film, with all the convenience of total portability.

Ansco

X-ray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CAREFREE *beauty*

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PLASTIC LAMINATE **DOORS**

947 Chemclad Doors have been custom made for Cobo Hall, Detroit, Mich. Architects and Engineers: Giffels & Rossetti, Inc.

From core to surface, custom-built Chemclad Doors are carefully constructed for a lifetime of *carefree* beauty. All doors are covered with Chemclad's extra thick, high-impact plastic laminate in a wide choice of beautiful wood grains and colors. Optional features include: Integral scuff plates, louvers, stainless steel edge angles, etc. Confidence is a built-in plus factor, too, because every Chemclad Door carries the full warranty of the most experienced manufacturer in the field. See us in Sweet's—or write for full details.

Representatives in Principal Cities from Coast to Coast.

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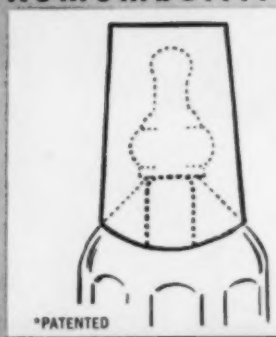
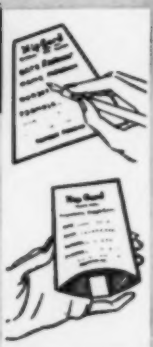
Remember...



*PATENTED

for quick, dependable protection to nursing bottles . . . use the original NipGard* covers. Exclusive patented tab construction fastens cover securely to bottle • For High Pressure (autoclaving) . . . for Low Pressure (flowing steam).

NipGard
TRADEMARK



DISPOSABLE NIPPLE COVERS . . .

provide space for identification and formula data . . . instantly applied to nipple; save nurses time...cover both nipple and bottleneck. Do not jar off. No breakage.

Use No. 2 NipGard for narrow neck bottle . . . use No. H-50 NipGard for wide mouth (Hygeia type) bottle. Be sure to specify type desired.

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Your hospital supply dealer has NipGards. Professional samples on request.

NEW!

COMPACT SIZE DOCTORS' ENTRANCE REGISTER

INSTALLS IN 1/4 SPACE REQUIRED FOR CONVENTIONAL UNITS

model shown (100 names) only 15¼" x 16⅜"

- Available in any multiple of 20 names.
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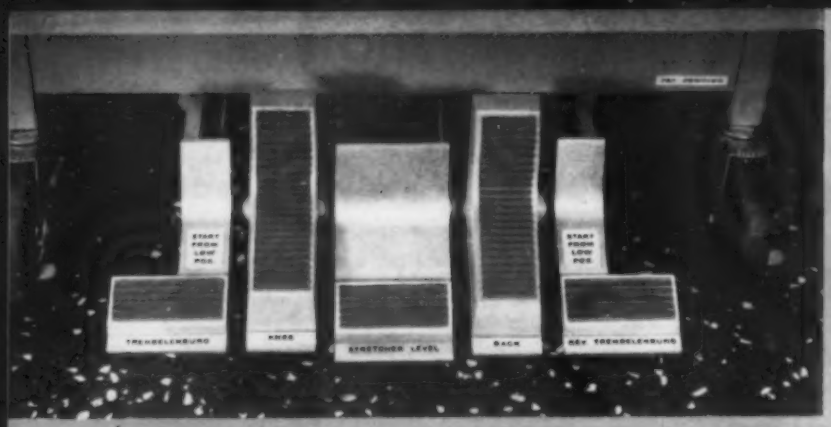
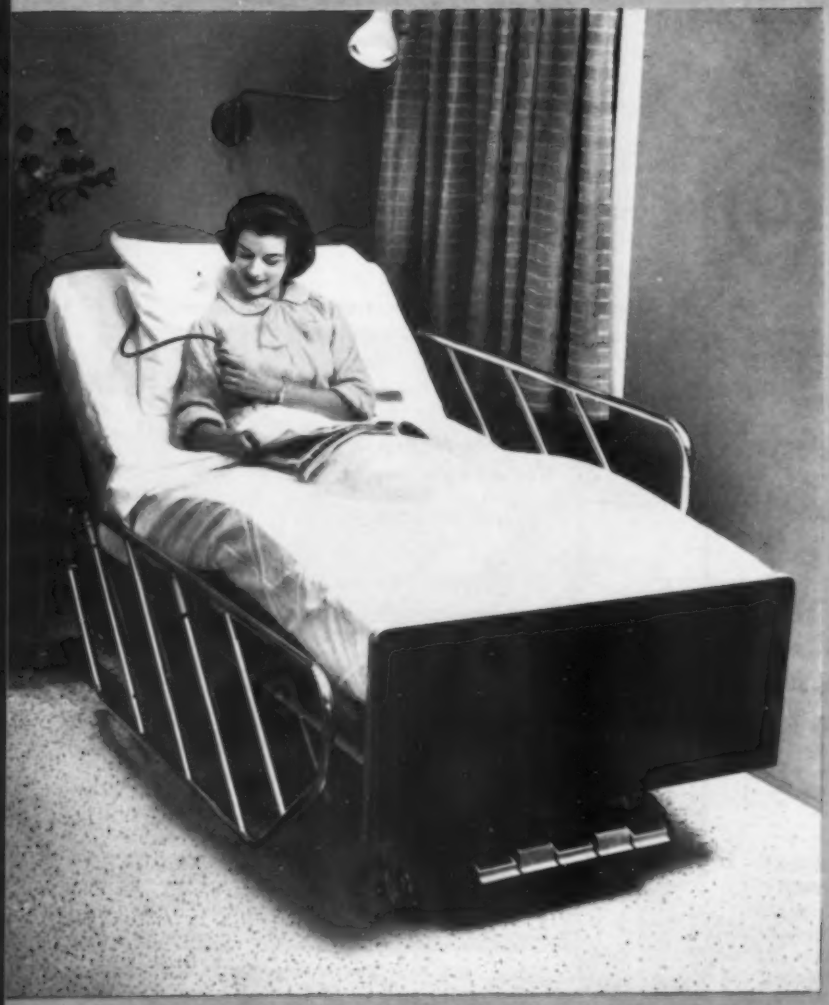


TOUCH-TOE Control

sets new standards of simplicity and convenience in the

All New Borg-Warner Hospital Bed



With handy control switch, patient can adjust movement of bed to positions pre-set by nurse with TOUCH-TOE selector—thus freeing staff for other duties. Master switch permits hospital personnel to immobilize entire unit. Bed is listed by Underwriters' Laboratories, Inc., for use with oxygen administering equipment.

Fully motorized—yet priced so low any hospital can afford it

Now—Borg-Warner brings you a fully motorized hospital bed without equal in simplicity, convenience and low cost.

With exclusive TOUCH-TOE position selector, there's no bending, stooping or reaching—just a touch of the toe selects the desired position, and patient control switch adjusts the bed, automatically, smoothly and quickly. It's as easy as that.

Equally important, the Borg-Warner bed is a marvel of simplicity. The single, low-amperage motor operates the bed through all positions: Trendelenburg, Reverse Trendelenburg, Stretcher Level, Knee and Back Rest, Fowler, High-Low, and Vascular.

In low position, the Borg-Warner bed is only 16 inches from the floor—at stretcher level a full 34 inches, 4 to 8 inches higher than any other motorized bed.

Designed in consultation with recognized hospital authorities, and thoroughly tested in leading hospitals, the Borg-Warner bed now puts the advantages of a simplified, dependable, fully motorized bed within reach of any hospital.

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BORG-WARNER

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DIVISION OF BORG-WARNER CORP.

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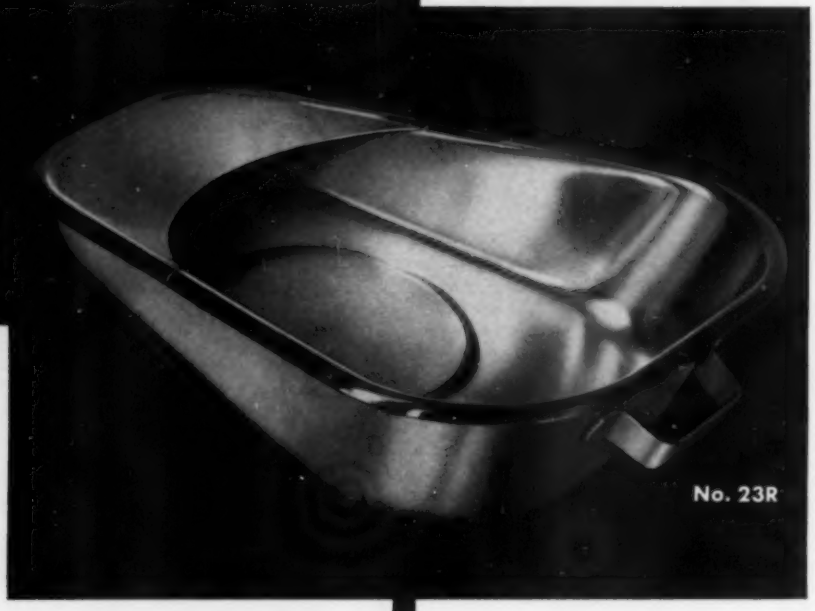
Greater Comfort,
Convenience, Safety

NEW POLAR WARE

stainless steel

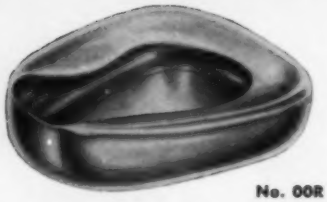
Fracture Bed Pans



No. 23R

From the patient's personal approach, or from your functional, practical point of view, the new Polar Ware fracture pan is preferred for bed service. Smaller in size and flatter in design than a pan of conventional design, it can be slipped into place far more easily . . . a convenience feature of special importance in caring for immobilized, arthritic, elderly or overweight patients. Special shaping aids substantially, too, in maintaining correct body alignment — provides maximum patient comfort and safety.

Constructed of heavy gauge stainless steel, Polar Fracture Bed Pans guarantee years of extra service . . . and because they're welded in one solid piece, they have a seamless, satin-smooth inside surface, completely free of crevices or any area that accepted aseptic methods will not make sterile. Leading supply houses from coast to coast carry Polar Ware Fracture Bed Pans — premium in everything but price. Ask the salesmen who call on you, or write



No. 00R

Also by Polar Ware — Panette No. 00R of heavy gauge stainless steel — scaled to children's size. Seamless construction.

No. 15R

Standard size Bed Pan No. 15R of Heavy Gauge Stainless Steel. Seamless construction.

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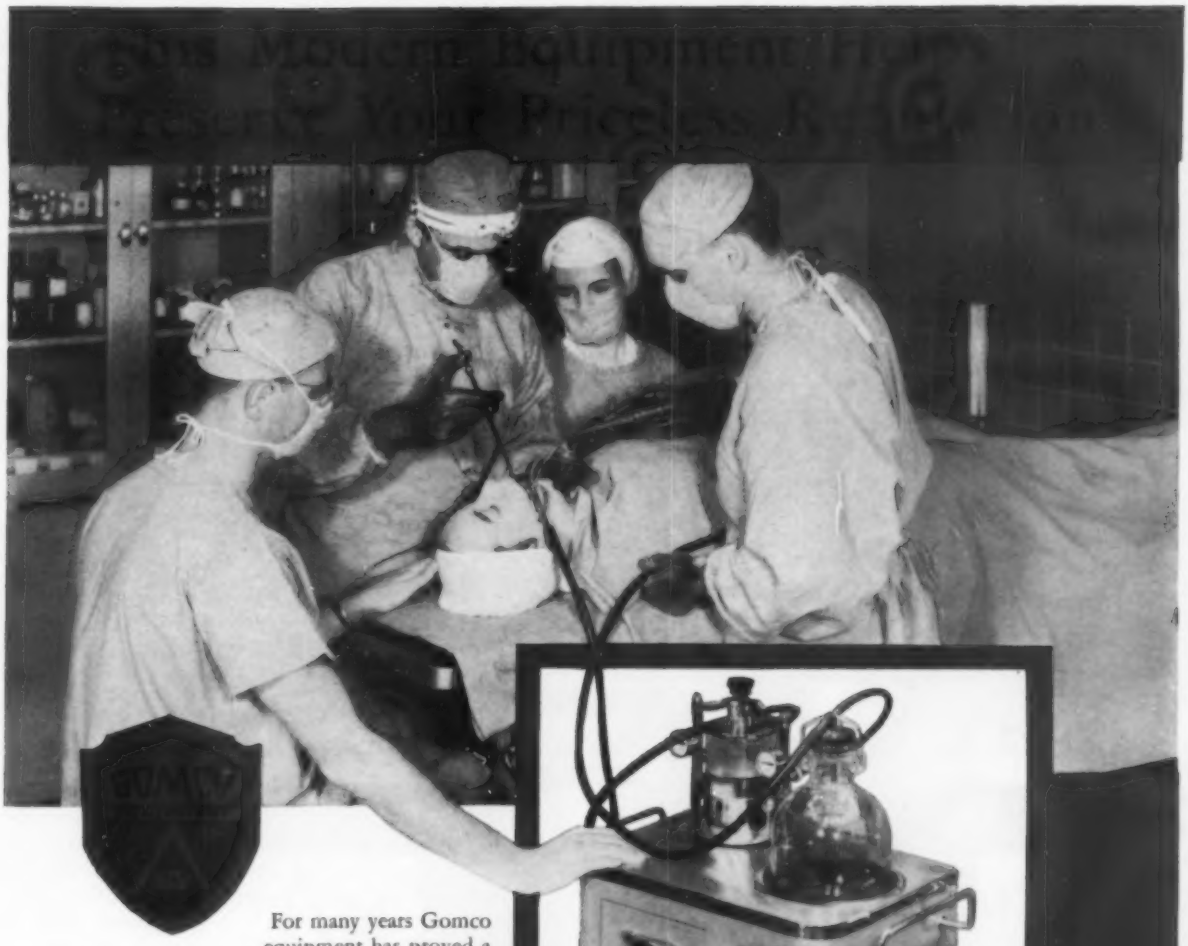

Gomco No. 927 Explosion-Proof Suction and Ether Cabinet ...choice of surgeries where the finest facilities are demanded.

For many years Gomco equipment has proved a valued ally to surgeons, nurses and staff in achieving the successful results that build reputation in the medical community.

An outstanding example is the Gomco No. 927 Explosion-Proof Hospital Unit for Suction and Ether Service. This double pump cabinet model offers the ultimate in safety. Quietly and dependably, it provides accurately-controlled ether-flow and precision-regulated suction.

Gomco Aerovent® overflow protection—automatically prevents flooding of the suction bottle, thus protecting the pump from damage.

Standard equipment of the 927 includes ether hook, suction tube, conductive rubber tubing and explosion-proof electrical connections.

Your Gomco Dealer will gladly demonstrate the 927, or any of the other models in the wide and varied line of fine, reliable, easy-to-operate Gomco equipment. Contact him today.

GOMCO SURGICAL MANUFACTURING CORP.

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Distributed Outside the U. S. A. and Canada by: **INTERNATIONAL GENERAL ELECTRIC COMPANY**
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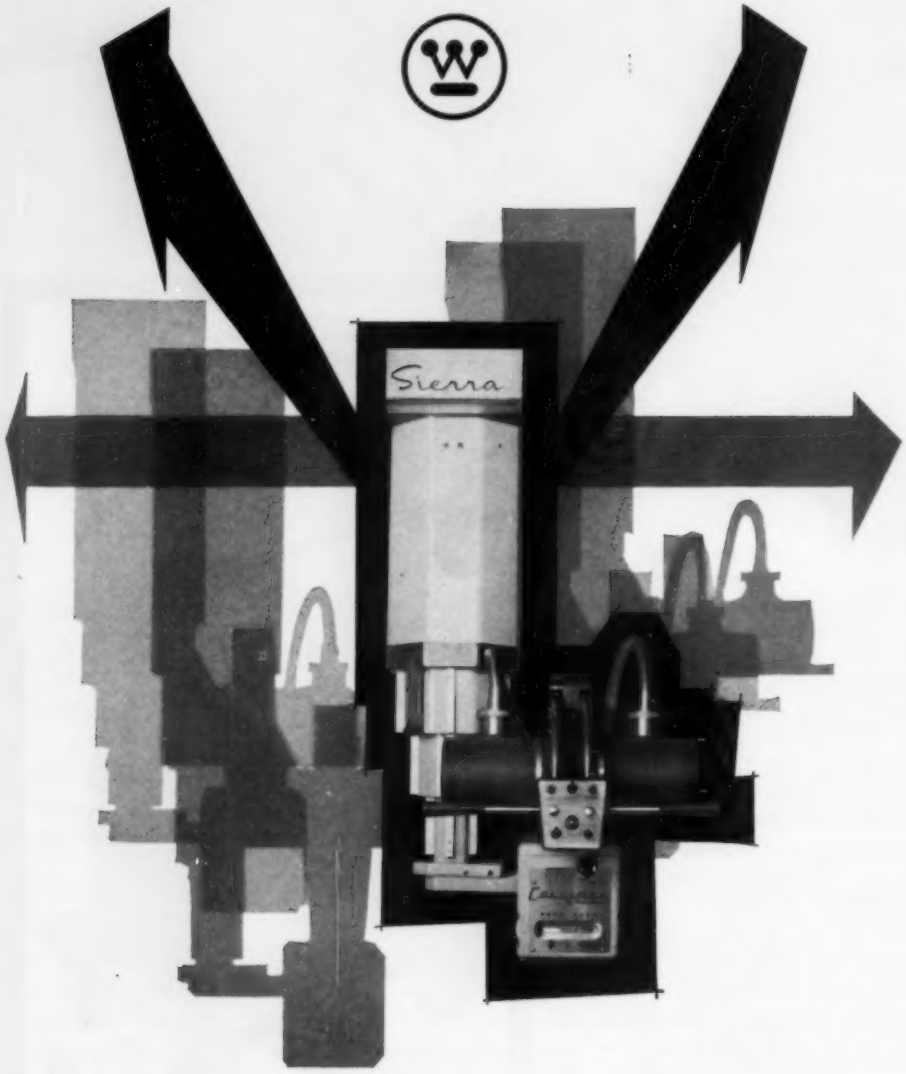
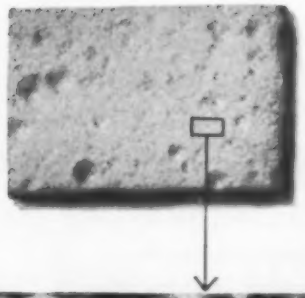
The new Sierra achieves the maximum in stability and in flexibility. This Westinghouse overhead tubesupport operates with minimum effort, throughout the room. The Sierra's rigid telescoping column is synchronized and weight-balanced. Permits 54 inches of vertical travel. Accepts all standard tubeheads. Takes optional accessories. Locks electrically. For more information: Westinghouse Electric Corporation, X-Ray Department, 2519 Wilkens Avenue, Baltimore 3, Maryland. You can be sure . . . if it's **Westinghouse**

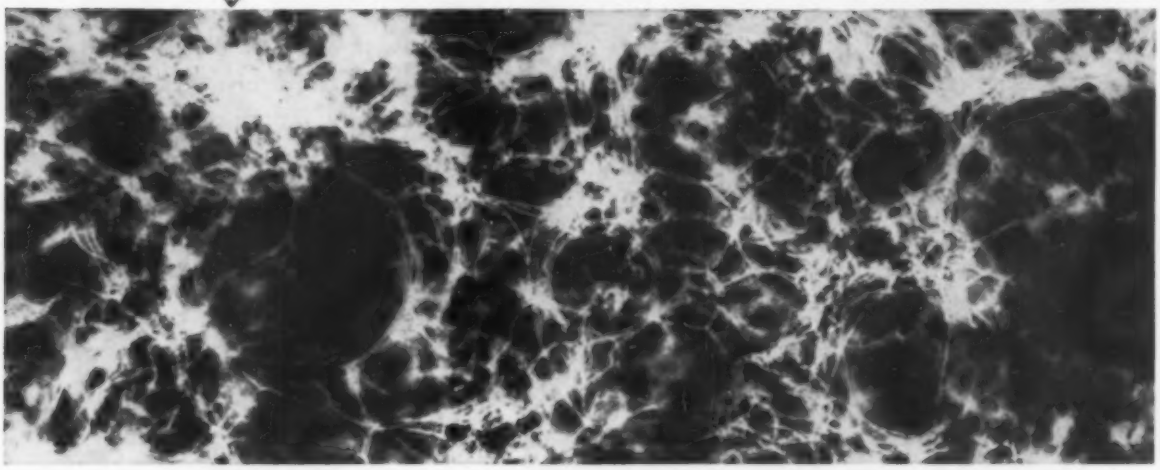
J-08391





here blood enters . . . stops . . . clots . . .

Cross section of Gelfoam (highly magnified)



Hemostasis with Gelfoam sponge is efficient and direct: blood enters . . . stops . . . clots. Later, Gelfoam is absorbed *in situ* with virtually no cellular reaction.

Hospital applications for Gelfoam are many—so varied that one or more of its uses may occasionally be overlooked.

So that your hospital can take full advantage of Gelfoam versatility, make certain you have the right Gelfoam on hand for every use. Gelfoam is supplied as sterile surgical sponge, dental pack, prostatectomy cone, biopsy sponge, sterile powder, and Gelfilm* for neurosurgery and ophthalmologic procedures.

Indications and effects: Gelfoam is an absorbable hemostatic material useful in many fields of surgery. With it, capillary oozing or bleeding from veins may be controlled instantly. When implanted in tissues, Gelfoam is completely absorbed in 4 to 6 weeks without inducing excessive scar tissue formation; when applied to bleeding skin or mucosa, it liquefies in 2 to 5 days.

Administration: Using aseptic measures, Gelfoam is cut to the desired size and applied either dry or saturated with isotonic salt solution or with thrombin solution. The prepared Gelfoam is applied to the bleeding point and held there for ten or fifteen seconds. When bleeding is controlled, the Gelfoam is left in place.

Storage and handling: Gelfoam may be stored indefinitely in the unopened package. After opening, unused portions should be discarded or resterilized by dry-air heating for four hours at 290° F. (143° C.). Sterilization by autoclaving cannot be employed.

*Trademark, Reg. U. S. Pat. Off.

Precautions:
Gelfoam should be used discriminately in arterial bleeding because of the intra-arterial pressure. It is advisable to suture and reinforce where possible.
Do not rely solely on Gelfoam in patients with hemorrhagic dyscrasias.
Gelfoam will not stop menstrual bleeding—do not use post partum or for menorrhagia.
Be sure Gelfoam is in snug contact with all of the underlying or involved surfaces.
Use Gelfoam as sparingly as possible in observation of the surgical dictum regarding "as little foreign material as possible in wounds."
Do not overfill cavities.
Be sure that all air bubbles are expressed from the Gelfoam to discourage possible growth of aerobic organisms.
Do not use in grossly contaminated wounds — the Gelfoam may liquefy too rapidly.
Avoid prolonged exposure of Gelfoam to contaminated air.

some of the capabilities of

Gelfoam* and Gelfilm*

Upjohn

- control bleeding from small arterioles
- control capillary ooze
- repair veins
- seal cerebrospinal fluid leaks
- obliterate dead space
- secure a dry operative field
- protect brain surfaces during retraction
- carry medication
- stop epistaxis
- patch small air leaks in reinflated lungs
- reinforce suture lines
- treat gastroduodenal hemorrhage
- facilitate closure and healing of large kidney wounds
- control hemorrhage following anorectal surgery
- control bleeding and oozing in bone surgery
- promote healing in skin ulcers
- serve as biopsy sponge

The Upjohn Company
Kalamazoo, Michigan

Coca-Cola, too, has its place in a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy.. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK
Coca-Cola
TRADE-MARK ®

DEPENDABLE PARCOA®

SOLVES PARKING PROBLEMS GIVES YOU CONTROLLED OFF-STREET PARKING

PARCOA
Johnson
SINCE 1909
Systems
BOWSER

Every month, more and more cars are appearing on America's highways adding to congestion and confusion. Parcoa offers the perfect solution . . . positive parking control—day and night . . . smoothly, safely, without interruption or overcrowding. PARCOA is an automatically controlled completely integrated parking system—not just a gate. You are offered a choice of controls . . . coded card key, coin operation, ticket issuing system or a time-dated ticket dispenser.

PARCOA will pay for itself many times over. 100% collection and ease of maintenance are assured. Before deciding on any parking control system investigate **PARCOA!**

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Subsidiary of BOWSER, INC.,
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When hospital supplies are needed, they're usually needed fast. Remember Greyhound Package Express. Even shipments going hundreds of miles can arrive *the same day they're sent!*

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You can ship anytime. Your packages go on regular Greyhound passenger buses. Greyhound Package Express operates twenty-four hours a day... seven days a week... *including weekends and holidays.* What's more, you can send C.O.D., Collect, Prepaid ...or open a charge account.

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Gentlemen: Please send us complete information on Greyhound Package Express service... including rates and routes. We understand that our company assumes no cost or obligation.

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COMPANY _____

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IT'S THERE IN HOURS...AND COSTS YOU LESS!

....Meets Today's Most Rigid O. R. Standards

Aluminum and stainless steel for superior conductivity, easy-to-clean, aseptic construction. Distinctive style, superbly functional

Alumiline operating room furniture is an Aloe exclusive development. Designed and fabricated entirely in our own factory, it has been given special features which make it uniquely fitted for use in the surgery.

Distinctive – Design-Coordinated

The graceful, distinctive, square-tube frames provide the strength and pleasing unity of design which are characteristic of the entire line. Alumiline is completely functional—every unit has been developed to serve a definite purpose with maximum efficiency. As a group, Alumiline is design-coordinated to meet the stringent functional demands of modern surgical technics.

Maintenance-Free Construction

Stainless steel and aluminum are combined to give permanent protection against corrosion and rust. Sturdy, welded construction assures lasting rigidity; exclusive H-frame cross bracing at the lower part of the unit provides unusual strength. In contrast to ordinary bolted construction, Alumiline will remain rigid permanently and will therefore last many times longer under the hard conditions of daily institutional use.

Aluminum parts are chemically oxidized and finished to retain a permanently smooth surface that is easy to clean and will never tarnish in normal use.

The stainless steel used in Alumiline has a No. 4 Satin finish, which reduces glare and shows no finger prints. The light weight of Alumiline permits easier handling; causes less damage to hospital floors.

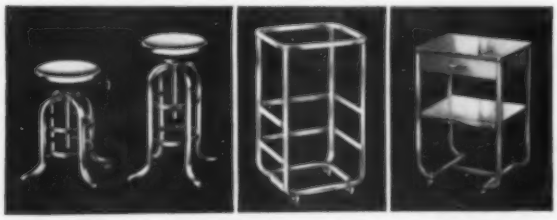
Electrically Conductive

Because of superior conductivity, aluminum and stainless steel are the preferred materials for use in the O. R. Alumiline in the operating room forms an important link in your chain of precautions against explosion hazards of static electricity.

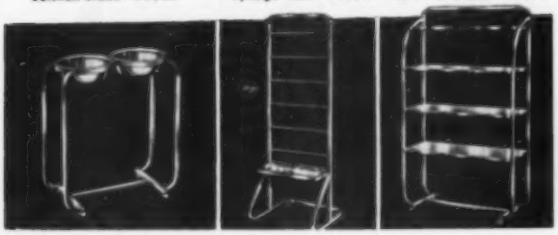
With the naturally conductive aluminum and stainless steel construction, conductive casters complete the cycle of safety measures that make Alumiline safe for use in the presence of anesthetic gases.

Write or see your Aloe Representative for complete information.

Operator's Stools—P9925—P9927 Linen Hamper—P9970 Utility Stand—P9943



Solution Stand—P9965 Sponge Rack—P9995 Instrument Stand—P9955



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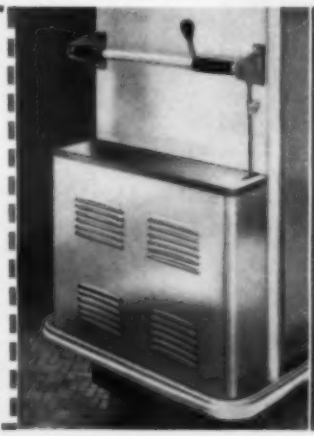

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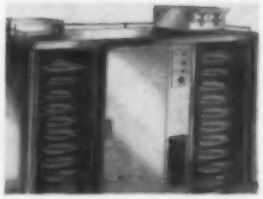
- PLUS NUMEROUS OTHER EXCLUSIVE BLICKMAN-BUILT FEATURES!!



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■ Lily® comes to the aid of hospital water service with a beautifully designed water pitcher that makes bedside beverage service a pleasure for both patient and nurse.

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What Does It Cost To Equip a Small Hospital?

Question: As a representative of a local financial group, I have been commissioned to obtain information preliminary to the establishment of a hospital in this area. At this time, we are especially interested in knowing the cost of equipping a 65 bed general hospital or in learning how we might estimate the cost.—W.L.T., N.J.

ANSWER: The United States Public Health Service, Division of Hospital and Medical Facilities, has prepared estimated averages of equipment costs. For groups II and III equipment these figures are $192,230 for a 50 bed hospital and $363,227 for a 100 bed hospital.* As a further guide, the per bed costs for equipment are estimated at $3845 for a 50 bed hospital and $3632 for a 100 bed hospital.

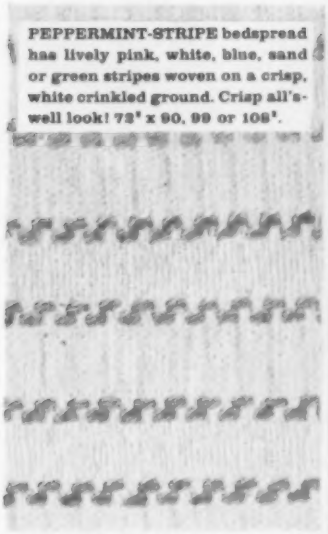
An additional guide to planning is the division's estimated averages of departmental equipment costs. The accompanying chart from the 1961 issue of *Hospital Purchasing File* gives the figures for 50 and 100 bed hospitals. The cost data were based on prices from more than 600 manufacturers and distributors of hospital equipment and materials.

Many communities will not include all of the services which were used as a basis for these estimates, so the total estimated cost can be reduced by the cost of any department which is not going to be included in the planned facility.

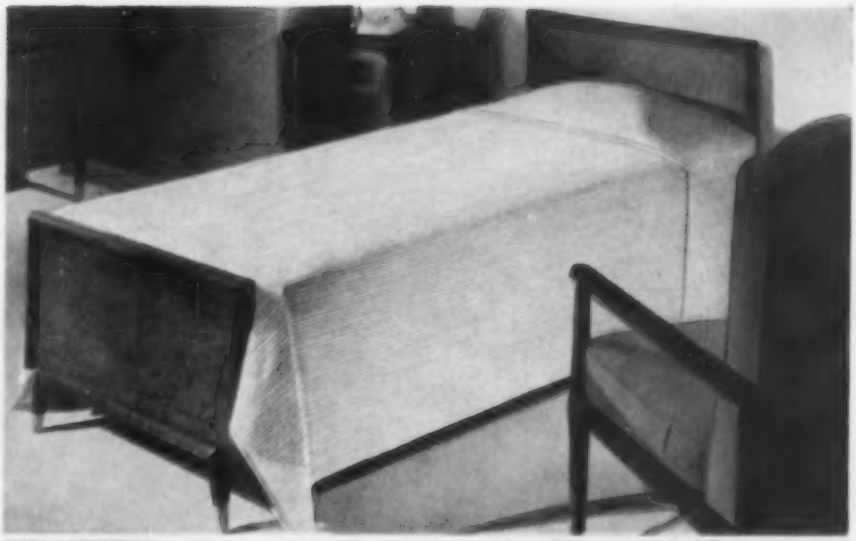
*Group II equipment is defined as depreciable equipment of five years' life or more not normally purchased through construction contracts, such as large items of furniture and equipment having a reasonably fixed location in the building, but capable of being moved. Group III equipment includes items which have a life of less than five years, normally purchased through other than construction contract.

P.H.S. Estimated Averages of Equipment Costs

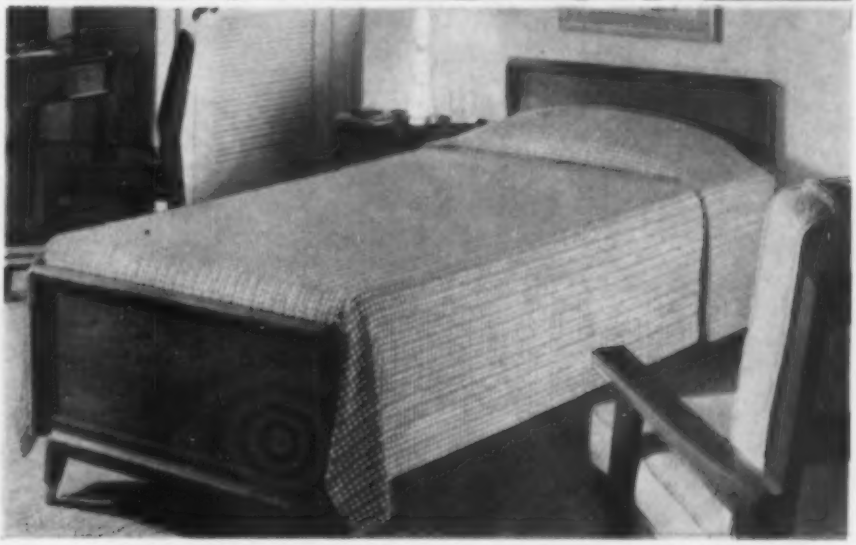
	50 BED GENERAL HOSPITAL			100 BED GENERAL HOSPITAL		
	GROUP II	GROUP III	TOTAL	GROUP II	GROUP III	TOTAL
ADMINISTRATION DEPARTMENT	$ 15,908.00	$ 641.00	$ 16,549.00	$ 34,736.00	$ 854.00	$ 35,590.00
DIAGNOSTIC AND TREATMENT FACILITIES						
LABORATORY DEPARTMENT	8,061.00	807.00	8,868.00	13,017.00	1,334.00	14,351.00
MORGUE AND AUTOPSY	521.00	—	521.00	813.00	—	813.00
RADIOGRAPHIC SUITE	29,116.00	620.00	29,736.00	67,526.00	1,033.00	68,559.00
X-RAY THERAPY SUITE	—	—	—	—	—	—
PHYSICAL THERAPY	6,652.00	93.00	6,745.00	9,974.00	159.00	10,133.00
OCCUPATIONAL THERAPY	—	—	—	—	—	—
PHARMACY DEPARTMENT	2,173.00	502.00	2,675.00	3,373.00	1,085.00	4,458.00
NURSING SERVICE FACILITIES	36,195.00	—	36,195.00	72,499.00	—	72,499.00
NURSERY FACILITIES	5,678.00	—	5,678.00	8,488.00	—	8,488.00
SURGICAL FACILITIES	12,055.00	—	12,055.00	33,861.00	—	33,861.00
CENTRAL STERILIZING AND SUPPLY FACILITIES	10,429.00	4,905.00	15,334.00	16,732.00	9,226.00	25,958.00
INSTRUMENTS	—	6,082.00	6,082.00	—	8,242.00	8,242.00
OBSTETRICAL FACILITIES	7,261.00	—	7,261.00	9,317.00	—	9,317.00
EMERGENCY DEPARTMENT	2,683.00	—	2,683.00	3,888.00	—	3,888.00
SERVICE FACILITIES						
DIETARY DEPARTMENT	9,785.00[2]	2,787.00	12,572.00	15,548.00[2]	5,357.00	20,905.00
HOUSEKEEPING DEPARTMENT	2,579.00	11,733.00	14,312.00	3,389.00	23,057.00	26,446.00
LAUNDRY DEPARTMENT	1,026.00	365.00	1,391.00	1,567.00	396.00	1,963.00
MAINTENANCE DEPARTMENT	925.00	393.00	1,318.00	1,586.00	884.00	2,470.00
CENTRAL STORE ROOMS	2,554.00	—	2,554.00	4,903.00	—	4,903.00
LOCKER ROOMS	592.00	—	592.00	623.00	—	623.00
OUT-PATIENT DEPARTMENT	3,861.00	—	3,861.00	4,496.00	—	4,496.00
DENTAL SUITE	3,179.00	2,069.00	5,248.00	3,195.00	2,069.00	5,264.00
TOTAL	$161,233.00	$30,997.00	$192,230.00	$309,531.00	$53,696.00	$363,227.00



PEPPERMINT-STRIPE bedspread has lively pink, white, blue, sand or green stripes woven on a crisp, white crinkled ground. Crisp all's-well look! 72" x 90, 99 or 108".



CITADEL is made especially for hospitals. Has white cord motif on yarn-dyed ground of light gray, yellow, aqua, blue, sand, pink, willow green, white. 72" x 99 or 101".



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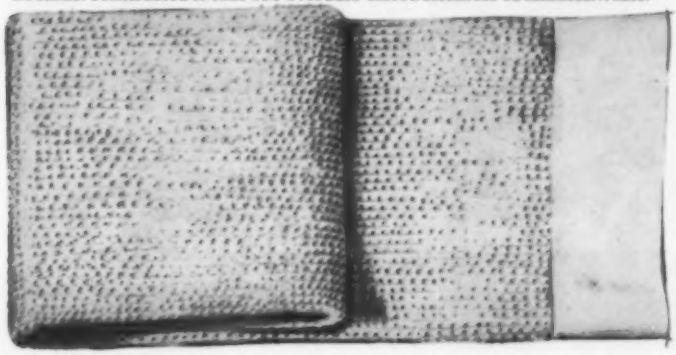

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wire from Washington

POLIO VACCINE EXPERTS TESTIFY

For two days Public Health Service's top research and administrative experts in poliomyelitis problems and Drs. Albert Sabin and Jonas Salk testified before the House interstate and foreign commerce health subcommittee.

Their objective was to explain why this country wasn't producing oral polio vaccine for general use. While the situation was thoroughly aired, the sessions produced no solutions.

At the end, it was clear that the roadblock is partly technical, partly administrative. Manufacturers have yet to discover a reasonably practical yet sure method for eliminating simian viruses — "wild viruses" found in the monkey tissue — from the finished vaccine. At the same time P.H.S. holds fast to its requirement that no oral vaccine will be released for general use unless all of these undesirable viruses are removed. In mass vaccination campaigns that already have taken place in other parts of the world damage to human beings from these viruses has not been established, but P.H.S. refuses to take chances. Its argument is that as long as this country has a safe vaccine — Salk — it would be needlessly risky to use a possibly dangerous one.

During the hearings, P.H.S. officials touched on one possibility that has the drug manufacturers slightly worried. They said that the agency already has considered going into the production of the new vaccine, which generally is administered by teaspoon in a sweet sirup. For the time, P.H.S. has decided not to produce and sell the product. However, as Surgeon General Terry said, "if private industry cannot or will not" develop the necessary technics for safe production, P.H.S. will again consider asking the Administration and Congress for the money to set up its own plant.

As of now, no manufacturer has actually applied to P.H.S. for a license to put the oral vaccine on the market, although they are exchanging information with government scientists. The manufacturers haven't yet worked out a process to eliminate all simian viruses, as required by P.H.S., that would be feasible for large-scale production.

In another development, President Kennedy has gone a long way toward settling one problem that has disturbed P.H.S. He is asking Congress for $1 million for purchase of oral vaccine to be supplied free to communities in case of epidemics. P.H.S. had been attempting to devise some system that would avoid the out-and-out public health approach, in deference to organized medicine.

When President Kennedy made his request, P.H.S. followed up with an estimate that the $1 million would provide about 3 million vaccine doses. This irritated Dr. Sabin, the vaccine's developer, who said the money would provide closer to 30 million doses. Asked about the differences of opinion at the House hearing, Dr. Terry said the P.H.S. estimate was "just an educated guess . . . perhaps not too educated." He went on to say that the actual price can't be determined in advance of production. It will be based on production costs and savings resulting from volume production. He said he hoped it would be cheaper than Salk vaccine, but he wasn't sure.

HEALTH BILLS FACE MOMENT OF TRUTH

An uneasy calm has settled over health-medical legislation.

President Kennedy has made it plain he will fight for such major bills as health insurance for the aged under social security and aid to medical and dental schools — but he hasn't said when the fighting will start.

The President has publicly recognized that on these issues, as on many others, his opposition is well organized and well financed.

American Medical Association and other forces lined up with it — including the American Hospital Association — are attempting to build grass-roots opposition to the health care bill, but they are handicapped by not knowing when or how the White House will move. They can't keep pressure on Congress indefinitely, yet they can't afford to let their members relax. With his definite but thin control over the Democratic machinery on Capitol Hill, President Kennedy can decide when hearings will be held.

In advance of the open debates, Wilbur Cohen, H.E.W.'s top lobbyist, is at work in Senate and House, gathering support for the aged care social security program. He has all the assistance he wants, and he will be one of the chief advisers to the President on timing.

Bill by bill, here are some of the developments:

Delay by states in changing their laws to comply with the Kerr-Mills nonsocial security plan for medical care of the aged is working to the advantage of the Administration and its compulsory plan. For example, a delegation from Oklahoma recently called on Sen. Robert S. Kerr to tell him bluntly that his law wasn't solving the problem in his state.

Oklahoma is one of the few states that has passed the enabling legislation so "medically indigent" as well as welfare patients will get medical care when they are past 65. Oklahoma's law states that an elderly person won't qualify as "medically indigent" if his annual income is over $900. Senator Kerr was told that 18 of every 20 aged

applicants for the new type of medical care had to be turned down on this means test.

At about the same time, Michigan's Blue Cross had to announce that its plan to extend hospitalization coverage to those past 65 without increasing rates was in trouble.

So far the program has cost $20 million, a penalty Blue Cross can't carry for long. This is a severe setback to the opponents of President Kennedy's social security plan. They are compaigning on the premise that voluntary health insurance can handle the financing of medical care for those past 65.

Sen. Hubert Humphrey (D.-Minn.), a supporter of the Kennedy program, is further complicating the Kerr-Mills situation by pressing for enactment of a bill that would guarantee the elderly welfare patient (or "medically indigent") complete freedom of choice of physician, hospital or druggist. Should this be enacted, it would add to the cost of elderly medical care in all states, and cause great confusion in states that have highly integrated programs of medical care for the aged.

Congress so far has shown no particular enthusiasm for President Kennedy's program of scholarships to able but needy medical and dental students, and building grants to medical and dental schools.

There is more lethargy than opposition, a situation that probably will change when the President really puts pressure behind these measures. On these bills at least the prospect is that opposition won't be along party lines, but will be based entirely on the cost of the bills. If the budget is way out of balance by the time these hearings start, they won't have much chance.

Minimum wage legislation, with its special peril for hospitals, is moving toward a decision.

American Hospital Association has succeeded in keeping nonprofit hospitals exempt, and placing them in a separate category distinct from hotels and motels. Labor has served warning it will fight hospital exemption from the minimum wage and hour provisions, maintaining that increases in hospital insurance premiums have not been reflected in hospital pay scales. As of now, proprietary hospitals with an annual gross of less than $1 million also are exempt.

HOSPITAL RENOVATION PLAN HITS SNAG

One of the President's pet projects — separate legislation authorizing Hill-Burton grants for renovating and modernizing large, old urban hospitals — is having its troubles, from an unexpected source.

American Municipal Association is pushing for a different type of grants program, under which P.H.S. would make grants directly to towns and cities. Free from any type of Hill-Burton priorities, the municipalities then would make their own decisions on where and how to spend the federal money. While this municipal lobby might not succeed, it could easily block passage of the original bill which would make the payments directly to the hospitals.

Sen. John Sparkman's bill to increase the grant fund for building student nurse and intern housing is making good progress, and probably will pass.

Congress voted $50 million for this program last year, but a White House order increased it to $100 million. Senator Sparkman would add on another $25 million each year for five years, bringing the total to an eventual $225 million. Among hospital planners, there is some question that all this money would be used.

Veterans Administration finds itself opposed to two bills that are moving ahead.

One would raise salaries of hospital managers and directors — many of whom are paid less than some physicians serving under them. On this, V.A. thinks a complete overhaul of its hospital pay scales is in order, not another patchwork job. The other bill would offer unlimited outpatient care for veterans of the Indian wars. Not many veterans are involved, but V.A.'s policy is opposed to special consideration for any one group of veterans.

Prospects are growing dim for any action whatever this year in the drug regulation field.

Just before he left office this year H.E.W. Secretary Flemming returned to Capitol Hill the identical bill his department offered last year. His successor, Secretary Ribicoff, has been too busy with other matters to look into drug questions. Also, Senator Kefauver, who ran last year's extensive investigation of the drug industry, is redrafting the bill he presented last year, but isn't ready to reintroduce it. So far the President has shown little interest in drug regulation legislation. His only public statement has been the suggestion that a "consumer's council" be created to advise Food and Drug Administration on drug problems.

NOTES:

Fulfilling a campaign promise, President Kennedy has called a joint heart disease-cancer conference to meet at the White House starting April 22. In charge will be Boisfeuillet Jones, special assistant for health and medical matters to H.E.W. Secretary Ribicoff.

Dr. Martin M. Cummings of the University of Oklahoma Medical School, who has served in Veterans Administration but is not a Public Health Service career officer, is the newly-named head of the Office of International Research being created at the National Institutes of Health. His deputy is Robert H. Grant, a P.H.S. career man. The new office will coordinate all P.H.S. and N.I.H. international medical research programs.

Hospitals and medical schools will receive the major share of $264,708 allocated by P.H.S. for 18 community cancer demonstration projects. Money will be used to train laboratory technicians in special technics of identifying cancer cells, provide courses on early diagnosis of cancer for rural physicians and make television films to acquaint the public with the value of cancer research.

Thirty-two scientists have received new P.H.S. five-year fellowship grants to encourage development of professional personnel for teaching and research careers in medicine, dentistry and public health.

The Modern Hospital
APRIL 1961

LOOKING AROUND

Promised Land

HOSPITAL administrators who have been worrying about the nursing shortage can relax. It won't be long before nurses will be at least as plentiful as rabbits, and administrators can handpick the ones they want to staff their floors. We're referring to practical nurses here, but the difference between practical and registered nurses is only a technicality anyway, according to this letter we got from a school for practical nurses. Correspondence school, that is. "As a practical nurse you do not have to assist at surgical operations nor be acquainted with thousands of medical terms and technics," the letter said. "Primarily you have to know how to care for a patient and follow the instructions of a doctor or registered nurse."

Our acquaintance with the superintendent of the school began a few weeks ago when we answered a newspaper advertisement offering information about this correspondence course. Since that time, we've had several of these long, cozy letters — and certainly no lack of information about the course and its benefits. Altogether, the coupon we sent in has brought us 27 separate pieces, from "Practical Nurses Wanted — Need Great in All Localities!" to "Wouldn't It Be Wonderful To Own a Diploma Like This — With Your Name *Here*?"

At first, we wanted to be a practical nurse because it was going to enrich our life. "You have opened a door that will lead you to one of the most beautiful and most rewarding experiences a woman can have," the first letter said. "Doctors, nurses and all members of the medical family are looked up to because they devote their lives to comforting those who suffer. As a nurse, you will enjoy the gratitude of your patients and the admiration and respect of your friends."

When she didn't hear from us right away, the superintendent understandably thought we might be worrying because the lessons would be too difficult for us. "No, our lessons are not difficult, and, yes, you can easily do them at home," she wrote reassuringly. "Many of our students tell us that they have felt sufficiently qualified, after receiving a small part of the instruction, to accept minor cases while still studying."

Furthermore, it was apparent from this second letter, a nurse's life is not only beautiful, rewarding and easy as rolling off a log — it's also lucrative. Pay was reported as varying from $45 to $65 a week. "And remember," the letter added, "in addition to a good salary on private duty work and elsewhere, the practical nurse sometimes gets her room and board as well — leaving her salary practically free and clear for clothing, for pleasure, and for saving!"

As it turns out, moreover, we aren't going to need any savings: "A life in practical nursing is secure and satisfying," our friend promised. "You are constantly meeting new people and making friends. Many of the people you will be living with are well-to-do. If you're lucky, you may be called upon to accompany your patients on vacations to fabulous resorts. The private duty nurse is like a member of the family and all her traveling expenses or hotel bills are paid for by the patient." Who needs money?

Under the circumstances, it seemed positively churlish not to sign up, and, as we hesitated, it developed that the superintendent had the same idea. "Perhaps finances have delayed you," she wrote in the third letter. "If so, I'm going to do something about that right now! The amount of the down payment, as well as the monthly payments, have been especially reduced for you, as you can quickly see by turning to the special application form I've enclosed for your use. You can pay as little as $5 down and $5 a month if you wish!" This special offer puzzled us a little, because the same $5 down and $5 a month plan had been offered as an optional "budget choice" in the first letter.

It must have been a mistake, we figured, and we were right. The very next letter brought another special offer, or trial offer, at only $3 down for the first four lessons. "See for yourself how quickly you can master them," our friend urged. "See how much fun it would be to have the kind of work that means association with wealthy people, opportunities for travel and for gracious living."

If we should decide *then* that we don't want to go ahead, the letter said, we can return the lessons and get our $3 back. "But I know you won't send them back," our friend wrote confidently.

The reason she is so confident is that "in only a few short months you will be ready to receive your diploma, your valuable pin and all your graduate honors and nursing equip-

ment." Fully described in an accompanying folder, these goodies include our nurse's cap ("finest quality muslin, popular button-down style"), graduation pin, face mask ("surgical style, so important in guarding against infection"), graphic charts ("for keeping daily records of your patient's progress"), salary receipt book ("to help you conduct your business affairs in a proper manner"), and diploma ("beautifully engrossed").

Well, our friend the superintendent is disappointed in us. Her last letter said as much. "I was hoping to be able to start you long before this," she said reproachfully. "Do you know that many of the girls who wrote for information at the same time you wrote already have completed their first ten lessons, and some have had work that helped pay for part of their course?"

Then, obviously concerned about what might happen to us, she told a grim story: "Some time ago a married woman came into my office to see me. That is, she had been married, very happily, to a man who made good money. But, while she had lived well, they had not saved anything, and he had a heart condition that made it impossible for her to get insurance. So, here she was, suddenly thrown back on her own resources. She had just enough money to enroll for the course. While she was talking, she said something that stuck in my mind: 'I answered your ad the first time almost three years ago. But I felt so secure that I didn't do anything about it. If I had only known then. . . .'"

Plainly, the nursing shortage is over. The few girls who don't rush into practical nursing for the nobility, glamour, money, honors and rewards it offers will come quietly when they get that last letter. Who wants to give her husband a heart attack?

Tough League

UNLIKE scientific and clinical investigation, which have always appeared to us to march in orderly fashion from observation to demonstration to conclusion, research in care or medical economics has sometimes seemed a haphazard affair of partially completed questionnaires and interviews with distracted housewives whose answers are subjective at best and often influenced, if not dictated, by the nature of the latest illness in the family or the doctor's manner on the occasion of the most recent visit.

Well, as it turns out, we aren't far wrong. Writing in a recent issue of *The American Behavioral Scientist*, a medical care researcher describes the hazards of the profession — in terms that make mountain climbing seem safe and sedentary.*

Everybody is opposed to illness and in favor of good hospital and medical care, the author acknowledges, but from here on things get pretty confused. "Some of the disputation in medical care comes from disagreement on fundamental facts," he says. "Some of it comes from divergence on essential goals, and much of it undoubtedly comes from disunity on the worth of methods."

The existence of disputation, disagreement, divergence and disunity in the field of medical care will come as no great surprise to hospital administrators, who have also been face to face on occasion with another lament of the social scientist: "The researcher, furthermore, is considered an outsider. The wise researcher in medical economics or medical sociology is one who remembers that the field has long been the special preserve of people with M.D. degrees. Others are there by sufferance. The researcher must steel himself to being ignored — whatever his message. He may say triumphantly or heatedly that he has at last discovered the precise form of medical practice and financing that would best serve 'the public.' Sadly, he finds that his public is often, for better or worse, the physician's public."

As a matter of fact, the social scientist who discovers anything at all in the field of medical care has fought his way over formidable obstacles. "It is not easy for the researcher to obtain new facts about the practice of medicine," the report says. "The usual sampling or polling or interview technics, as they might be addressed to doctors, are almost useless. Physicians do not open or read much mail. . . . Questionnaires are a waste of stamps — even when endorsed by medical societies. Doctors have high costs of operation, so that to give an hour to an interview costs them $25 to $50. . . .

"Moreover, physicians are organized into well financed associations with . . . the inevitable public relations experts, hired specifically to save the profession from any and all critics. The public relations people in the medical field are in positions of power and can think of numerous reasons why particular research studies will not perform 'a useful service.'"

Nevertheless, useful research in the field of medical care is possible and necessary, the author believes. "However imperfectly, the job must yet be done," he concludes. "We need to know the relationship of medical practice to the economy. We have to ascertain the conditions under which society can best profit from the activities of its medical schools, hospitals, physicians and other institutions and specialists. . . . Opportunities for all kinds of behavioral science research exist in a field so criss-crossed by . . . emotion. . . . The political scientist can have a field day with studies of pressure groups, analyses of legislation, and medical issues as factors in political campaigns. The economist can work with price indexes, supply and distribution of medical resources, and related topics.

"The opportunities are there. But this is not quiet, library-type doctoral dissertation research. It is a tough league, made no easier by the inevitable presence in it of those who see the necessity of destroying the ruggedly entrepreneurial physician group as a preliminary to socializing various aspects of the economy.

"To be effective in such a field, the researcher will have to bring into play all that he knows and all that he can learn of the organization of society and the factors that make for change in a democratic republic. . . . Open-minded on facts and visionary in sensing ultimate consequences of inaction or innovation, the researcher in medical care can make a beneficial mark in society."

Pondering the social scientist's dilemma, we concluded that part of the problem, at least, must emerge from the strain of trying to be open-minded about facts without being sure of what a fact is. The researcher who is visionary in sensing ultimate consequences may make his beneficial mark, all right, but he is more likely to be called politician than scientist.

*Bornet, Vaughn Davis: Research in the Economics and Sociology of Medical Care. American Behavioral Scientist. 4:8 (February) 1961.

P.H.S. study gives major causes of noise in hospitals and recommends methods of controlling them

How To Keep Hospitals Quiet

PEOPLE in hospitals talk too much – and too loud. Talk by staff members, talk by visitors, talk by other patients – and the ring of the telephone that prefaces much of the talk – ranked highest among "annoying sounds common to hospitals" in a recent survey of several eastern institutions. Close behind the conversation, in terms of annoyance to patients, comes the clatter of cleaning equipment, buckets and trash containers.

Results of the survey made by acoustical engineering consultants* corroborated the suspicions long held by the Division of Hospital and Medical Facilities of the U. S. Public Health Service that hospitals generally are disturbingly noisy and that many of the noises could be eliminated or reduced in intensity. Because of its concern with the problem, the Architectural and Engineering Branch of the Division undertook the study to determine what changes in design and equipment can help to reduce noise in hospitals.

Survey Technic and Findings

Studies covering two 24 hour periods were made in the medical and surgical nursing areas of eight hospitals. During this time, continuous graphic noise level chart recordings were made in a corridor and a patient's room. Concurrently, samples of the actual sounds were made on a tape recorder that operated at fixed time intervals. The equipment was monitored continuously by the engineers who also noted on the noise level charts the sources of all unusual and predominant noises. Later, in the consultants' laboratory, the tape recordings were analyzed and data in the form of octave-band analyses were drawn up for the composition of the over-all sound levels as well as for a number of specific sounds. (See charts on page 86.)

As an adjunct to the study, questionnaires were sent to recently discharged patients to ascertain their opinions of sounds noted during their stay, and to determine which noises disturbed or annoyed them. The questionnaires alone, however, were not the means of indicating the conditions that were the basis of noises. Several reasons account for this: (1) The size of the hospitals varied and the number of questionnaires returned by patients of each hospital varied disproportionately to the size of the hospitals. (2) Some patients apparently construed the questionnaire to be a "complaint form" and were reluctant to answer fully. (3) There was some misunderstanding about the identities of sounds and noises referred to. (4) Some patients

*This article presents a summary of the findings of a special survey relating to noise in hospitals, conducted by Lewis S. Goodfriend and R. L. Cardinell of Montclair, N. J., consulting engineers in acoustics, in collaboration with the sponsors of the study, the Architectural and Engineering Branch of the Division of Hospital and Medical Facilities, U. S. Public Health Service. The detailed report of this study is soon to be published by the Public Health Service.

Patients' reactions vary according to individual concepts of what constitutes noise

were inclined to accept certain noises as inevitable or an "inherent" part of hospital functions, while others noticed or indicated that they were disturbed by sounds not noted by the investigators. Another shortcoming, as mentioned previously and as is usual when questioning persons, is the element of subjective response based on the individual's concept of what constitutes noise.

To evaluate the noise problems in the hospitals properly, the questionnaires were analyzed in conjunction with the investigators' observations and the tape recordings of the sounds. The questionnaire returns were tabulated according to the patients' reactions to specific sounds that they considered to be annoying while hospitalized and analyzed to determine whether there may be a relationship between these sounds and those tape-recorded and charted.

Graphic charts were prepared for each hospital showing the two 24 hour cycles of the over-all background sounds levels, average hour-by-hour background levels, and octave-band measurements of specific sounds. The measurements and recordings were compared with noise level criteria and showed a close correlation between many of the questionnaire replies and the characteristics of the noises. These graphic measurements of the over-all composition of hospital noises and sounds made throughout the entire day and night provide the first factual graphic data of such noises to be recorded. From the graphic charts, tape recordings, questionnaires and investigators' observations, it was possible to evaluate the noises and their sources and to recommend corrective measures.

The cryptic listing of noises and noise sources as given in tabulations, of course, cannot tell the entire story. Within some areas a number of noise-producing items of equipment or operations, or both, required separate consideration. It should also be noted that while all the hospitals surveyed have substantially similar facilities and perform the same functions, only a few of the annoying sounds were found to be common to all of the hospitals.

Thus it was necessary to determine the variety of causes responsible for the different sounds resulting from similar environments. As observed by the consultants during their inspection of the medical and nonmedical areas of the hospitals, most causes were the results of inadequacies often pertaining to the same types of equipment and facilities. Some of these include improper location of mechanical and operational equipment and facilities, inadequate use of vibration-isolation methods for equipment, faulty installation or poor design of equipment, communication systems, housekeeping activities, patient service facilities, personnel activities, and visitors.

A total of 514 usable questionnaires was returned. The tabulation of the questionnaires listed 61 identifiable sounds noted by the patients as "annoying." These sounds affected one patient in one hospital to as many as 125 patients in seven hospitals.

The sources and their annoying sounds common to most of the eight hospitals in the survey, including those noted as having awakened patients, are shown in Table 1.

As tabulated from the questionnaires, 50 sounds caused 139 patients (almost a third of the replies) to awaken from sleep. Some of the sounds noted were of a nonrecurring nature or otherwise irrelevant to this summary. Omitting this group and

Table 1 — Patients Were Annoyed by These Sounds Common to Most Hospitals Surveyed

Sounds/Sources	No. of Hospitals
*Telephones	8
*Staff talk in corridors	8
*Visitors' talk in corridors	7
*Talk in other patients' rooms	7
*Cleaning equipment, buckets, trash containers	7
*Walking in corridors	6
*Food service: dish and tray clatter	6
*Carts: medicine, linen, other	6
Radios or television sets	6
*Other patients in distress, babies, children crying	6
*Floor kitchen and utility room activities, equipment	5
*Voice paging	5
Toilet flushing	5
*Floor polishers	5
*Traffic noises	5

(Asterisk indicates sounds that caused patients to awaken.)

those already included in Table 1, the other most prevalent sounds that caused patients to awaken are listed in Table 2.

Another group of sounds was observed and recorded on tape, then noted on noise level charts by the investigators. This group involves functional sources, such as mechanical and operational equipment or service facilities. Some of the more prominent noises that were observed are shown in Table 3.

The sources and sounds shown in these tabulations indicate a continuing situation which could be corrected. Although some of these occurred in only one or two of the hospitals surveyed, their causes require as much consideration as those having a high incidence score. Such sources and their sounds reflect a condition that usually would be found in other hospitals, under similar circumstances.

Character, Sources of Noise

The tabulations of hospital noises and sources show that they fall into two general groups: those of exterior origin and those of interior origin. Because the interior noises are numerous, this group was divided and further subdivided into those caused by mechanical facilities, operational facilities, and operational activities involving patient services. This summary follows the general divisions but omits the detailed analyses described in the complete report. The technical points and detailed measurements given in the report will be of particular interest to hospital administrators, equipment manufacturers, and architects and engineers concerned with hospital design and construction.

Exterior Noise Sources

Methods of eliminating or abating noise should begin during the initial

Table 2 — Patients Were Awakened by Sounds From These Exterior and Interior Sources

(In addition to those noted in Table 1)

	No. of Hospitals	No. of Patients
Exterior sources		
Truck delivery, early morning	1	1
Sirens	2	2
Lawn sprayers	1	1
Personnel cars arrive or leave, a.m. and p.m.	2	2
Police and ambulance radios	1	1
Interior sources		
Patients' talk, early morning, night	2	4
Nurses' station noises; chart cases	1	2
Changing shift	1	2
Recovery room sounds	1	2
Bedpan washer	1	1
Arrival of new patient; new roommate admitted	4	4
Moving equipment; chair scraping	2	2
Corridor noise and activity, p.m. or early a.m.	3	5
Noise from stairway; footfalls, talk	1	1
Pans or objects dropped, banged	3	4
Ice pitcher service, midnight and early a.m.	1	1
Elevator doors	1	1
Night emergency	1	2
Preparation for patient care, early a.m.	1	2
Kitchen employes at elevator, early a.m.	1	3
Patient in cafeteria line, breakfast	1	1
Door slam	1	1
Medical machine or oxygen tent equipment, same room	2	2
Exhaust fans	1	1
Delivery room door left open	1	1
Milkman and kitchen employes, loud talk	1	1

Table 3 — Mechanical and Operating Equipment That Cause Annoying Sounds

Dishwashers
Blowers improperly mounted
Refrigerators in floor kitchen and at nurses' station
Air conditioner improperly mounted
Roof blowers
Window fan at nurses' station
Drinking fountains
Cabinet drawers at nurses' station and in floor kitchen
Pumps
Compressor piping
Elevators, brake noise, switch gear
Reverberant stairway
Service driveway too close to certain rooms
Louvered corridor doors to various noise generating rooms

ELIMINATION OR REDUCTION OF NOISE SHOULD START EARLY IN

planning stages of a hospital and should continue after the hospital is in operation. In the early planning stage, the site should be selected only after consideration has been given to traffic noises in the vicinity, *i.e.* from a highway, railroad or airport. A site near a steeply graded highway carrying truck traffic, especially if there is a traffic light near by, should be avoided if possible.

The building should be oriented so that the nursing and the convalescent areas are shielded from traffic sounds. This involves planning the auxiliary buildings so that they may act as sound barriers to deflect noise from the hospital.

Parking areas for visitors and personnel should be located so that they will not contribute to outdoor noise. Employes coming and going at the change of shifts in the early morning or late at night can cause disturbing noises if their parking area is located too close to patient areas. However, the visitors' parking area, which is just as noisy, does not seem to be as annoying to many patients because it is used only during the day.

The location and construction of loading platforms for food and supplies also are important considerations. Platforms should be located and constructed so as to confine the noise that usually accompanies parking trucks and unloading and handling of supplies. Interior loading docks should be provided, or, at the very least, an overhanging, acoustically treated roof or canopy should be constructed over the loading platform areas. Regardless of their construction, however, loading platforms should not be placed facing a wing that is a patient area.

Interior Noise Sources

The number of interior sounds, of course, exceeds the number of exterior sounds and may be grouped in several categories according to different sources, such as mechanical equipment, operational facilities, and activities of the hospital involving the patient services.

The integral mechanical units of the hospital structure are often inherently noisy, but if carefully selected and properly specified, their noise need not be so intense when it reaches the patient areas. Noises from these sources are transmitted by vibration through the structure, the piping, the ducts, and through the air. Mechanical equipment should be mounted on appropriate vibration isolators; flexible pipe and duct connections should be used, as should resilient pipe hangers and sound traps.

Measurements can be made of the noise levels of existing equipment of the type which might be contemplated for use in a proposed hospital. Such premeasurements can serve to determine the extent of the sounds that may be transmitted to various points in the hospital. Most equipment can be designed to operate quietly. In the designing, thought should be given not only to function but to the assembling of components and installation methods. For example, noise levels can be reduced in the design of such items as dishwashers, sterilizers, refrigerators, pumps, air conditioners, and exhaust fans. Furthermore, they should be located where their noises will not radiate to other areas of the hospital.

Tables of recommended maximum sound levels for various types of equipment, as well as sound level criteria for various spaces within the hospital, are contained in the full report and will be useful in specifying minimum noise levels in selecting equipment. Detailed recommendations for vibration isolators, sound traps, and other mechanical units, in addition to design goals for noise control in equipment, are also presented in the report.

Although elevator noises are relatively inconspicuous during normal daytime activity, these sounds are sufficiently high to disturb patients at night and during daytime periods of comparative quiet. Elevators, therefore, should be located away from patients' rooms, if possible. The location and housing for the switchgear should be carefully planned to prevent noise transmission, and the door closure mechanism and motors should be so specified as to ensure quiet operation. Close mechanical control of the leveling of the cab in the shaft is necessary to prevent the noise caused by carts, particularly when loaded with utensils and glassware, as they are pushed on or off the cab.

The selection, location and installation of drinking fountains warrant attention. In the hospitals surveyed, the noise was intermittent and the cycling of the compressor was noticeable along the entire corridor. The level was sufficiently high to awaken patients in near-by rooms during the late evening and early morning hours. Careful maintenance would correct some of this noise, but a remotely located, central chilled water system would alleviate the noise problem of drinking fountains.

When the doors of patients' rooms are directly opposite on each side of the corridor, sound is transmitted directly from one room to the other. The moaning of a patient in pain, loud talk by visitors, and the noise of personnel activities can be disturbing to the patient across the corridor. Most patients' rooms are provided with small toilet rooms, and the flush valves were found to be another source of annoying noises. The use of silencers on flush valves would correct this at small cost.

THE PLANNING STAGE

Partitions between patients' rooms present no problem so far as the materials are concerned. However, for good sound transmission-loss construction, these partitions must be properly sealed. Holes for plumbing and electrical equipment should be caulked. Electrical outlets or fixtures placed back-to-back on walls between rooms should be avoided. A poorly painted, porous concrete block partition may let 10 times as much sound through as does one in which the paint bridges the pores. A gap of one-quarter inch where a partition is joined to a mullion, as in a curtain-wall, will permit the conversation in one room to be clearly audible in the adjacent room.

Some of the major sources of vibrating and reverberating noises are the facilities needed to operate a hospital. These include refrigerators and dishwashers, sterilizers and autoclaves; special plumbing; furnishings such as bed curtains, metal sinks and cabinets, chart cases and racks; housekeeping equipment such as vacuum cleaners and floor polishers, and communications systems such as voice paging and call buzzers or hand bells. Frequently, the noise problem from these sources can be lessened by initially selecting proper equipment. For instance, many hospital refrigerators at the nurses' stations proved to be much noisier than the domestic types of comparable sizes found in today's homes.

Adequate preventive measures minimize the noise producing potential of some equipment. For example, application of a damping compound similar to that used for undercoating automobiles will reduce the impact noises made when objects are dropped or strike against sinks, dishwashers, carts and other sheetmetal equipment. Also, plastic materials or

(Text Continued on Page 87)

Ducts Provide Free Passage for Sound

Ducts, through which fresh air is carried from the outside to the air conditioning equipment and from the equipment throughout the hospital, also effectively transmit sound from one place to another. The noises from the air conditioning equipment can travel along the metal wall of the duct or through the airspace of the duct and reach the nursing areas of the hospital as well as the nurses' stations, utility rooms and work areas, and administrative offices. The ducts can convey sound from one room to another room served by the same duct. Thus, a noise from one patient's room can enter the ventilating duct of the adjacent toilet room, be transmitted to the toilet room above, below or adjacent, and then be radiated into a near-by patient room.

The basic methods for counteracting air conditioning duct noise are simple. Short sections of canvas or other suitable sleeving can be used in the duct to provide a break in the path of mechanical vibration. The noise within the duct can then be further reduced, either by using a sound trap or by lining a long section of the duct with an acoustical material.

Duct lining is most effective in small ducts of about 12 by 12 inches or less. In larger ducts, lining in combination with lined turns and lined plenums can be effective, but must be weighed both economically and mechanically against the use of prefabricated sound traps. The use of lined ducts involves a higher cost for the duct itself. However, the static pressure of the system is increased little. The prefabricated sound trap usually costs less than an equivalent acoustically lined duct, but because it creates a higher pressure-loss than does a lined duct, its cost should be considered against that of the lined duct. Where space is at a premium, however, a sound trap is the better solution.

It should be noted that lining is not recommended for ducts serving areas where asepsis is important, such as the operating and delivery rooms, nurseries and treatment rooms.

Where one duct serves a number of adjoining rooms, the duct should be lined or a trap should be placed between the rooms, if there is a possibility that noise from one room may disturb the occupant of an adjacent room. This recommendation applies to the toilets of patients' rooms where the toilets are stacked vertically or are alternated with other patients' rooms on the same floor.

At Hospital H, the ventilating duct for the floor kitchen passed through the ceiling and wall of the linen closet. The resultant sound radiated through the sidewall of the duct and transmitted noise to the floor, particularly in the patients' rooms near the closet.

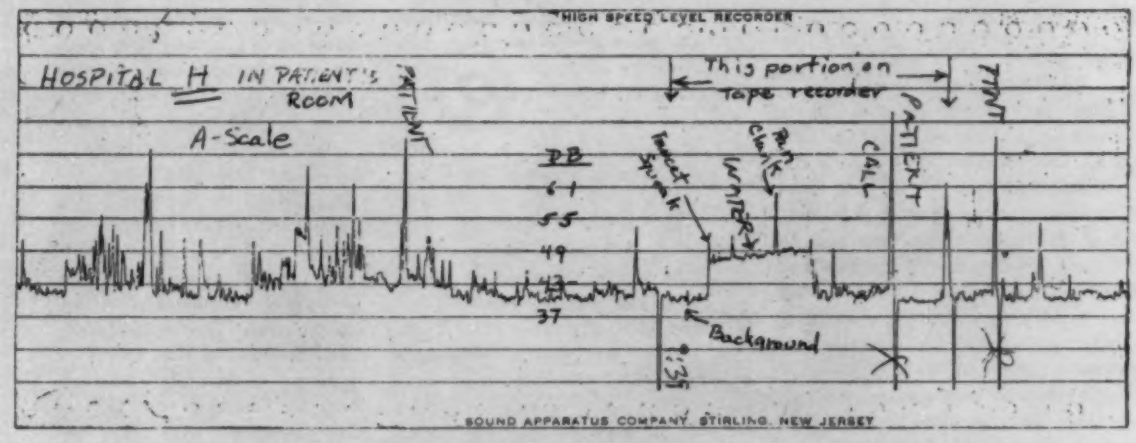
A common misunderstanding about the nature of fan and duct noise is the fact that noise will travel against the direction of air flow as readily as it will travel in the direction of flow. Many times, air-handling systems are equipped for sound reduction on the supply side while the return side is left untreated. Noise then reaches all the areas served by the air-return duct system. One reason many of these systems are not noisier may be that the return air is frequently drawn through an adjacent toilet room, thus providing some sound isolation between the patients' rooms being exhausted and the fan. A corridor ceiling should not serve as a plenum for a hospital system where conditioned air is to be directly supplied to and exhausted from every room.

SOUND CHARTS PAINT A GRAPHIC PICTURE OF HOSPITAL NOISES AND SOUNDS

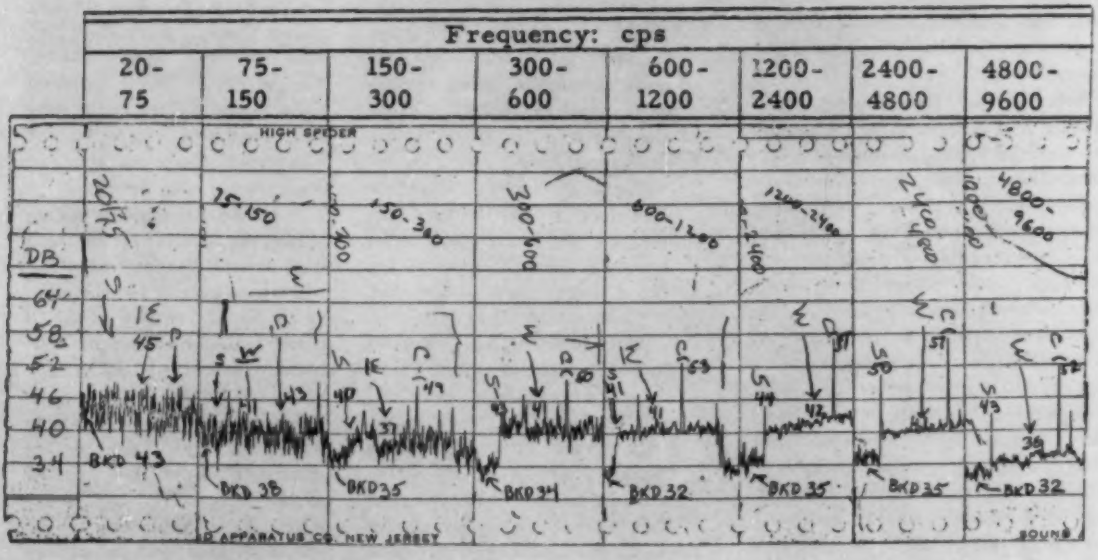
Upper chart shows sample of original sound level chart recorded on hospital premises, annotated as to sources of sounds. Lower chart shows analysis made from concurrent tape recording. Chart at bottom shows tabulated values read from the analysis. "Cps" refers to cycles per second; "db" to decibels.

MICROPHONE IN PATIENT'S ROOM: Time: 9:39 P.M.

Hospital H



ORIGINAL A-SCALE CHART RECORD



OCTAVE BAND ANALYSIS
Sounds From Nurses' Station

Data Tabulation								
Frequency: cps	20-75	75-150	150-300	300-600	600-1200	1200-2400	2400-4800	4800-9600
Background level: db	43	38	35	34	32	35	35	32
Faucet squeak	-	-	40	43	41	44	50	43
Water running	45	41	37	41	41	42	41	36
Clank of pan	-	43	49	50	53	57	57	52

(*Continued From Page* 85)
laminated metal sandwich construction can be used to reduce noise from some sheetmetal units.

Other noise problems can be minimized through administrative directives. Floor polishers used late at night when other activities are subdued, loud conversation inconsiderately carried on by the housekeeping staff (at times by the nursing staff), too-rapid handling of the bed curtains are a few examples of noise sources which can be controlled.

The noises created by patients and their visitors, radios and television sets are among the most difficult to control. While the remedy for this is largely a matter for the hospital administration, the proper use of acoustical materials and other abatement measures, as discussed in the report, would go far toward reducing the annoyance from these sources.

Recommendations: Work Areas

Much of the disturbing noise emanates from the utility room and the nurses' station. This is because of the activity at these locations and the equipment used in them. They must, of course, be located where they will best serve their function. But a little forethought in planning will usually achieve a measure of isolation and functional adequacy.

The activity of the hospital employes as they attend to patients' needs can, at times, be disturbingly noisy. The nursing unit traffic pattern should be studied to determine
(*Continued on Page* 160)

SOUND TRAVELS THROUGH THE HOSPITAL ALONG MANY PATHWAYS

Sound is transmitted through a building in two ways:

1. By direct radiation of the sound waves in air; this is known as airborne sound.

2. By transmission through the structure or piping; this is known as structure-borne sound. In most cases, structure-borne sound is transformed into airborne sound before it reaches the human ear.

In the open air, as the distance from the source increases, the intensity of a sound diminishes rapidly. This is because the original sound power must be distributed over the surface of an ever-increasing sphere. When a sound is confined in a space, such as a room or hallway, the sound power is mostly contained within the boundaries and its intensity does not diminish so rapidly.

Reflected sound waves help to maintain the sound level over great distances, as in a speaking tube. Although treating the ceiling with acoustically absorbent material eliminates some of the reflected waves, the hard walls and floors in a hospital corridor tend to carry sound along.

Airborne Sound

Airborne sound can travel out an open window, strike a wall or some other part of the structure, and be reflected back to a number of adjacent rooms. Airborne sound passes readily through small openings and cracks. Closing the door to a room will greatly reduce the sound entering the room, but if the door is not properly gasketed and sealed at the threshold, much sound will still enter. Ventilation louvers in doors also offer little resistance to sound.

A thin panel or wall is not effective in reducing sound transmission. Sound waves are set into motion by the impinging waves and produce new sound waves on the other side of the wall. A thick, solid wall, or one of double construction, is required effectively to block the transmission of sound between adjacent rooms. Back-to-back electrical outlet boxes often allow sounds to be transmitted from one room to another.

Structure-Borne Sound

Sound waves pass easily through solids and consequently can travel considerable distances. Structure-borne sound also exhibits the peculiarity of skipping certain areas and reappearing at various distances from the original source.

Structure-borne sound often arises when machinery is not properly isolated from the surrounding structure or connecting pipes. This medium is also responsible for widely transmitting impact sounds, such as hammering and footsteps.

As was pointed out earlier, structure-borne sound is generally transformed into airborne sound before it becomes audible. At the receiving end, a panel, wall or floor is set into vibration because it is in contact with the pipe or part of the structure carrying the solid-borne sound waves. This panel, presenting a large surface to the air, produces airborne waves of considerable dimension. The sounds are amplified in much the same way as the sound board of a piano amplifies the tones of the strings.

If the panel or wall has a resonant frequency that corresponds to the original sounding source, the resultant airborne sound will be reinforced and especially pronounced. In other instances, panels can be affected by vibrations that do not correspond to their resonant frequencies and produce entirely new sounds as the result of the combined frequencies.

Structure-borne noise can be effectively reduced by properly isolating all machinery from the building structure and piping, by installing resilient supports, such as pipe hangers, and, where necessary, by providing breaks in the structure itself. In planning the acoustical details of construction, the engineers should ensure that transmission paths do not flank other structures. For instance, an improperly fitted door in a double wall that isolates the construction for a room can render useless an otherwise good acoustical construction. It is much easier to eliminate structure-borne noise in the planning stage than it is to provide remedial measures after the building is finished. ■

A.C.S. Report:

Intensive Care Units Help Give Doctors Peace of Mind, Surgeons Told at Meeting

PHILADELPHIA. — Surgeons welcome the intensive care unit as an improvement in patient care, it was apparent here last month at a meeting of the American College of Surgeons.

At a symposium on the intensive care unit, surgeons and nurses attending the meeting heard Dr. Thomas H. Ainsworth Jr. of the department of surgery, Bryn Mawr Hospital, Bryn Mawr, Pa., describe how the advent of intensive care units has relieved the physician's worries about nursing management of his patients:

Because of his heavy reliance on the nursing staff, the physician has viewed with concern the trend which is taking the nurse away from the bedside and requiring her to assume more and more the role of administrator.

"In the care of most of his patients he has been willing to accept a licensed practical nurse, the nurse's aide, the orderly, and other hospital personnel. But in the care of the acutely ill he has felt that the nurse must again assume her bedside role, for only the professional nurse has the understanding, technical skill, and knowledge required to treat these patients and follow the effect or lack of response to treatment by frequent observation.

"Thus the physician has welcomed the advent of a special unit within the hospital where the acutely ill patient can receive the maximum professional care," Dr. Ainsworth declared.

An administrator on the program, Dr. Pascal F. Lucchesi, medical director of the Albert Einstein Medical Center, supported the view that intensive care units are essential today:

"Every hospital should have one," Dr. Lucchesi said.

Nurses taking part in the program described how intensive care units are organized and managed. Describing the origin of intensive care, Faye G. Abdellah, R.N., Ed. D., of the Division of Nursing Resources, U. S. Public Health Service, said the concept actually originated in the Nineteenth Century, when "the head nurse recognized that she could do a better job if her sickest patients were placed nearest her desk."

Dr. Abdellah reported the studies of progressive patient care by a Public Health Service research team. "An effective classification system can help provide a picture of the medical and nursing requirements of all patients in the hospital," she said.

Some flexibility in the system is necessary for the most effective allocation of hospital resources, Dr. Abdellah said. "It has been estimated that one swing bed is needed for every three intensive care beds," she said. "A flexible zone in effect serves as a buffer zone which can absorb increased demands that cannot always be predicted."

Selecting patients who require the maximum amount of nursing care makes it unnecessary to divide patients into medical and surgical, male and female, ward and private groups, Dr. Ainsworth reported, describing the operation of the unit at Bryn Mawr.

Control of admissions and discharges must be in the hands of a single individual, he said. In most hospitals this would be the chief resident, it was suggested.

"It has been our policy to permit no direct admission to the intensive care unit," Dr. Ainsworth reported. "The patient is first sent to the accident ward emergency room, where he is evaluated by the chief resident. Treatment is then instituted, and, if necessary, the patient is admitted to the intensive care unit."

Admission to intensive care is not compulsory at Bryn Mawr, Dr. Ainsworth related, but is optional for the attending physician in each case.

"However, in the absence of adequate private duty nursing, the administration of the hospital should have the authority to require transfer to the intensive care unit," he added.

Experience at Bryn Mawr is that physicians will use the intensive care unit if they understand that their patients will receive better care under these circumstances, it was reported.

"It is wise to have physicians represented in the planning committee for the unit," Dr. Ainsworth said. "These physicians can then explain the unit in detail to the staff through special communications, or in a staff meeting, so that all questions regarding the unit can be answered before it is instituted.

"The physician must be convinced of the desirability and the feasibility of the unit, as he is the person who must orient the patient and his family to this facility. At the Bryn Mawr Hospital, one staff meeting was devoted entirely to explaining the intensive care unit."

Periodic evaluation of the inten-

(*Continued on Page* 183)

Dr. Walter Questions Hospital Sanitation

PHILADELPHIA. — Hospitals will not combat staphylococcus infection successfully until they become "as sanitary as a brewery or biscuit factory," Dr. Carl W. Walter, associate clinical professor of surgery at Harvard Medical School, said here last month at a meeting of the American College of Surgeons.

Dr. Walter estimated that as many as 5 per cent of surgical patients in U.S. hospitals may develop staph infections. He described the continuing study of sources and methods of transmission of infection that is in progress at the Peter Bent Brigham Hospital, Boston.

Dr. Walter, who has produced two moving pictures on hospital infections, "Hospital Sepsis — A Communicable Disease," and "I Dress the Wound," said many industries have standards of cleanliness and sanitation exceeding those that are commonly found in hospitals.

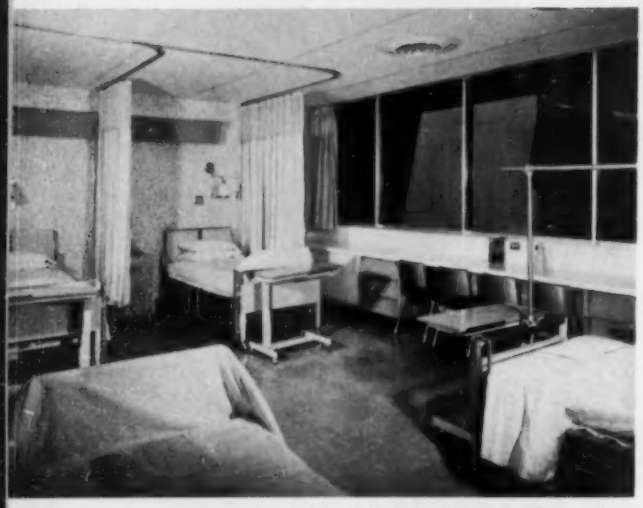
Main entrance of hospital is screened from the street by this ornamental steel grille.

Photographs by Julius Shulman, Los Angeles

Orthopedic hospital specializes in surrounding patients with warmth and friendliness

Design Helps Make Long Stay Seem Short

PROVISION of a warm and friendly atmosphere for its young, long-stay patients was a primary consideration in planning the new $6.5 million Orthopaedic Hospital, Los Angeles. Many dramatic departures from orthodox hospital design of the last 25 years are evident in the design of the six-story structure, the last unit in the hospital's master plan to convert the 40 year old institution to an orthopedic center. Typical of the hospital's concern for the special needs of its patients is the provision of sleeping accommodations for parents to stay with their children when the need arises. Other ways the hospital has been designed for its special function are illustrated and described on the following three pages.



Typical four-bed ward, above, has pastel wallpaper, picture window, and built-in storage space. Each of the four surgeries has its own adjacent scrub area, like one shown.

Fallout Protection Included in Orthopaedic Hospital Plan

Surgeries at Orthopaedic Hospital are underground for protection from earthquakes and radiation fallout. Adjacent are an eight-bed recovery room and central supply.

Closed-circuit television projects from surgery to the 96 seat seminar room which is used for the three-year resident physician program.

The second floor for rehabilitation patients is connected to the rehabilitation center by covered bridge. Pediatric patients and those through age 21 are on the third and fourth floors. The fifth floor is used for adult private patients. Completion of the sixth floor will be done as necessary to bring the bed size to 160 beds from its present 130.

Pediatric floor has its own recreation-dining room, which is also used as a schoolroom for children

Colorful fairy tale, animal and cartoon character murals decorate the nurseries. All murals, mobiles and three-dimensional cutouts were donated by Walt Disney for the nurseries, wards and private rooms on the orthopedic-pediatric third floor of the new center.

A recreation-dining room is provided for the pediatric and rehabilitation floors. This one on the pediatric floor is used further as a schoolroom for long-term hospitalized youngsters. A teacher provided by the board of education also holds bedside classes.

T-plan of nursing floors at Los Angeles Orthopaedic Hospital saves nurses' energy

On nursing floors, the building's T-plan permits strategic step-saving location of nurses' stations. Each floor is self-sustaining and has its own supplies, linen and examining rooms, pantry, refrigerator and hot plates. Patients' rooms and wards are equipped with intercommunication systems and television outlets. ■

Main lobby is highlighted by the stained glass windows of the small nonsectarian chapel. Wood panels are of walnut. A part of pharmacy can be seen at left.

On nursing floors the building's T-shaped plan permits strategic step-saving location of the nurses' station in center. The one shown above is on the pediatric floor.

An administrator must be able to change without being changeable and to shift his position as circumstances require — without being shifty

Administrator Must Be Adept at Adapting

Ray E. Brown

THE most important thing the administrator administers is change. In a real way, administration can be defined as the constant reconciliation of the organization to constantly recurring change. Unless he is flexible, the administrator cannot expect to accommodate to the shifting circumstances which constantly confront him and the organization.

Administrative accommodation is always a difficult thing. First there is the problem of morality — right and wrong. At what point does administrative flexibility begin to equate with amorality and represent an unconcern with right and wrong? When does the liberal view become that of the libertine? There is, of course, no absolute answer except at the extremes. Most situations faced by the administrator cannot be answered for him by the Ten Commandments or by a catechism. At best, these provide him only with general laws which he must interpret for specific situations. They point the general direction he should go, but they do not work out the trail for him. He is largely on his own as he tries to cut an administrative path without cutting moral corners. This means that he must develop a set of convictions as to goodness and badness so as to have a moral compass.

The problem with convictions is that they are what the individual believes and not necessarily what he ought to believe. They are dangerously like prejudices, and the individual who has them usually can't tell the difference. Both represent frozen beliefs, and both are equally difficult to change. The administrator needs the strength of his convictions, but he also needs to check them occasionally to be sure that he really is standing up for his convictions rather than leaning on his prejudices.

Because he cannot always separate his personal beliefs from the organization's purposes, the administrator sometimes becomes a crusader and sees himself as a man with a mission rather than with a program. Under such circumstances he prefers to push a cause rather than the organization's objective and to involve the organization in issues that it did not create and cannot correct. This means he uses the organization as a tool to further his own personal ideology rather than have the administration serve as a means to obtain

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the stated ends of the organization. He forgets that there can be a difference between those who do good and those who do well, and that you can sometimes get burned while carrying a torch. No less an authority than Jesus stated, "Render unto Caesar that which is Caesar's and unto God that which is God's."

The administrator with a cause believes in change, but he usually wants to change everything but himself. He is prone to become self-righteous and fall for the idea that the king can do no wrong. He is likely to practice a sort of self-communion and insist on taking his text from the scriptures according to the Administrator. The big trouble with the high-minded is that they can become high-handed. Too often they adopt an attitude that the ends they seek justify any means necessary. They may develop a special brand of intolerance and want to support it with righteous wrath and moral indignation. They see themselves as men of high principles but do not always realize that they may have the wrong principles, or that there is a chance that they might misapply them.

Outmoded Policies and Practices That Still Work Represent a Great Hazard to the Administrator

The tendency to develop a single value concept sometimes handicaps the administrator's ability to adjust to changing situations. Such individuals cannot adjust because they cannot compromise. They do not see that most good is accomplished at the expense of other good and that choices are usually between different values. Also, gains are seldom made that do not require some form of sacrifice. There are few choices where the gain is absolute and one must usually take a little of the bad in order to get the good.

For example, those of us who believe strongly in free enterprise may be smart to accept, and even seek, government intervention on problems that cannot be handled privately, but which endanger far larger areas that are being successfully managed under private means. It is the largest total value to be derived, rather than the largest single value, that should control the administrator. A number of smaller values may far outweigh a single value, no matter how large it may be. Decisions may be partly right and wrong at the same time in the sense that they both help and hurt. If administration is in fact a matter of risk-taking, it must mean that certain values are often jeopardized.

The administrator can be locked into his own mistakes by worshiping precedent. The origin of certain policies and practices in an organization may be so ancient as to be unknown, but their continuing wisdom goes unquestioned.

They are perpetuated because they have become a symbol of the firm, and anyone who questions them is classed as an organizational agnostic. Like the lighthouse that now burns its light so bravely several miles inland, because of a shifted shoreline, certain administrative policies may have saved the corporate ship in days gone by. Most administrative policies lack the picturesque appeal of old lighthouses, however; to outsiders the analogy is more like continuing to cook on a kerosene stove.

The fact that a thing once worked well, or even that it still works, should give it no administrative "pass." The kerosene stove probably works better today than it did in grandma's time — but this isn't grandma's time. The outmoded policies and practices that do still work represent the greater hazard to the administrator. They are like a concealed leak in a water main that reduces the vitality and strength of the stream without being suspected.

The worship of precedent isn't the only cult with which administrators sometimes affiliate. Most every administrator joins the "holy-cow" sect at times and places certain policies and practices off-limits to reconsideration by himself or anyone else. These are holy because they are so closely identified with the administrator. They are his brain-children — but they may only demonstrate the thickness of his head. He should be careful what he puts his administrative trade-mark on. Even better, he can stay off the defensive more often if he guards against committing himself too early and too strongly to courses of action with which he later will be closely identified.

The pull of affiliation and identification is a powerful force in favor of the status quo. We often defend the status quo because we helped create it, or think we did. But we also defend it simply because we are associated with it. It is a sort of virtue by association that causes us to defend many things merely because we are linked to them.

The administrator, of course, is responsible for all poli-

cies and practices in the organization and naturally feels that an attack on any policy is an attack on his administration and on him personally.

In my own experience I have at times found myself going to great lengths to explain and justify practices that I really did not understand myself. On occasion it has later turned out that the practice I defended was not what we were supposed to be doing at all and that I was sanctifying someone's error.

Change does not necessarily mean that things have been done wrong in the past, but the failure to make needed changes is a guarantee that they will be done wrong in the future.

The status quo seems to have an ideological appeal to administrators. One can say that the usual administrator is a conservative. The nature of his work tends to make him that way. The maintenance of organizational stability is a prime function of the administrator, and his effectiveness, and most often his administrative life, depends upon his protecting that stability. He can afford only as much change as he can reconcile with stability; he tends to seek change in small packages and on the installment plan.

The Effective Administrator Soon Learns That the Open Mind Is an Inviting Entrance to Interference

Organizational control is another administrative function, and this requires a high degree of conformity unless different members and parts of the organization are to go off in all directions at the same time. Innovation is a natural enemy of conformity, and the administrator must hold it within limits unless he is to lose control and become simply the figurehead for a free-wheeling organization. The need for conformity affects not only the willingness of the administrator to recognize and cater to a changed environment but tends to make him suspicious and distrustful of other members of the organization who attempt to introduce change. The role of continuity in operating efficiency is also likely to sensitize the administrator against novelty. Operating smoothness depends upon a well charted course of action and upon a well trained organization. Familiarity that comes with continuity of policies and practices is the means to both. The advantages of continuity tend to make the administrator more concerned with shaking down the organization than with shaking it up.

All organized effort is by definition structured effort. By the same definition, it is also conditioned effort. The administrator soon learns to be cautious about tinkering with either the structure or the conditioning. His chief concern becomes one of keeping the organization in the groove.

The effective administrator also learns, however, that there is a significant difference between being in the groove and being in a rut. It is the difference between holding the organization steady and holding it down. His willingness to make appropriate concessions to the realities of a constantly changing environment will determine the extent to which he actually functions as an administrator, or simply takes over the role of organizational caretaker. This does not mean the administrator must give up his conservative outlook. The consequences of his actions are usually of such importance to the enterprise as to require that he look before he leaps. The fact that he is the last check-point at which ideas are examined dictates that he act with restraint and with caution.

None of these factors, however, justifies his failure to reorient the organization continuously to an altering environment. A conservative driver doesn't drive on the wrong side of the road and doesn't exceed the speed limit. But neither does he park in the middle of a busy highway.

Along with being conservative, the effective administrator is likely to be determined in his goals. He knows how easy it is to have a program sidetracked by inattention or opposition. He also knows the value of momentum and that even a modest change in direction can in itself produce a strong braking action. He learns that he cannot deal simultaneously with all his problems and that he has to dog some of them tenaciously one at a time. He also learns that there is a danger of the tractable being detracted and that an open mind is sometimes an inviting entrance for interference. All of these things mean that the administrator must develop a certain level of stubborn purposefulness if objectives are to be accomplished instead of moth-balled. This level is a fine one, however, and the purposeful can too easily become the obstinate. Steadfastness is an appealing disguise for mulishness, but acting like a mule doesn't often pass for horse sense. The effective administrator realizes he must stay on course; he also knows that balking at necessary change can cost him the administrative steeplechase.

The tendency to confuse practices with purpose sometimes prevents us from acclimating the organization to emerging circumstances. The administrator should be concerned with goals and fix the policies and practices to fit these goals. It is the policies and practices, however, that make up the operations since goals are ends and not means. The administrator tends the goals by supervising the policies and practices. This means that his attention and interest become centered on the functioning rather than the function, and he worries more about how things are done than about what is done. Whatever concern he has about change involves better ways of doing instead of better things to do.

A middle-aged spread in administration is a hazard of successful organizations. Because things are going well the administration tends to let well enough alone and rest on its laurels.

(*Continued on Next Page*)

It grows tolerant of its environment and reacts to the forces being generated by the environment only to the extent necessary to maintain respectability. It quits running scared and develops a disdain for its competition. It knows it has the resources and the ability to outrun the opposition so it ignores the progress the opposition is making. For enterprises that have reached the top, life would be wonderful if life stood still. The problem is that life won't stand still. This problem is a larger one to those on top than to those below. The top is never an ideal spot on which to coast or to ignore the road signs that signal sharp turns ahead. The administrative complacency that may come with success can make the organization a victim of its own excellence.

Administrative slumber may be due to the inability of the administrator to recognize changes in the environment. The drift into organizational ineffectiveness can be gradual and unnoticed unless the administration maintains a sharp lookout. Changes in the environment are often subtle and obscure, and if the administrator waits for the backfire to awaken him, he may sleep through the time when adjustment was easiest, or even still possible. The administrative siesta can sometimes go undisturbed for long periods because the organization may make its own adjustments if the administration fails to do so.

The one sure thing about organizations is that they will continuously change. Usually most of this unplanned change is a natural adjustment in the general direction of the goals of the enterprise. It represents spontaneous responses on the part of the different individuals and segments of the organization to the problems and situations constantly confronting them and their activities. Up to a point such subformal responses are essential at each level in the organization if the work is to be accomplished smoothly and promptly. The alternative would be an impossible spelling out of every eventuality. This in turn would create an impossible amount of red tape if individuals were forced to follow such minutely prescribed policies and procedures. Its effects on the initiative and morale of the members of the organization would be even more devastating. For these reasons effective administration draws only the formal outline and depends upon the subformal responses at the point of contact to paint in the detail. These subformal responses provide a means for the parts of the organization to maintain a flexible position and comfortably accommodate to the contour of the shifting environment.

These natural adjustments at the point of contact with the environment can keep the enterprise on general course for a time somewhat the same as a blindfolded person feels and bumps his way across a room. But sooner or later the changing landscape becomes too unfamiliar, the enterprise that plays blindman's buff with its environment ends up in the rough, or up against a stone wall. The failure of the administration to make the necessary changes in the general course of the enterprise can no longer be obscured, after this happens, and radical adjustments become the order of the day.

Loyalty Is an Adhesive That Helps Hold the Organization Together, and Disloyalty Simply Cannot Be Tolerated

Administrative changes may be delayed, or never attempted, because such change often requires the administrator to change his mind.

This is not an easy thing for him to do. Aside from the emotional problems faced by all individuals in admitting they were wrong, the nature of the administrator's work can place serious difficulties in the way of his changing his mind. Because of the need for the administrator to demonstrate decisiveness when he moves administratively, he has a tendency to act too positively and to over-commit himself.

Similarly, because he is action-oriented, he seeks the strongest support possible for each idea he attempts to implement and thus has a tendency to over-convince and to oversell others. Both these tendencies can delimit the area of maneuverability later needed by the administrator if he is to make any necessary adjustments because of changing circumstances.

All decisions take on the meaning of contracts. They are in the nature of treaties with the different parties affected. Those affected have a right to depend upon the decision and to plan accordingly. This makes it exceedingly difficult for the administrator to change things when they need to be changed, and if he has promised too much, or sold others too strongly, his difficulties are multiplied when he has to change course. To those adversely affected it appears that the administrator is reneging on a promise.

Closely related to this problem is the importance that administrators necessarily attach to loyalty.

No one knows better than the administrator the compelling role of organizational loyalty. It is an adhesive that helps hold the organization together, and disloyalty is appropriately considered a cardinal sin organizationally and one which simply cannot be tolerated if the organization is to function effectively.

The administrator also knows that loyalty can be purchased only by trading in kind and that he gets back only the loyalty that he gives. Further, by some kind of moral alchemy loyalty supersedes almost all other values in the minds of most people, and the administrator is expected to do outrage to other values for the sake of loyalty. Because

the administrator cannot ignore the bonds that loyalty sometimes imposes upon him, he does not always have a free hand in making needed changes. While there is no complete answer to his problem, as regards the demands of loyalty, the administrator should remember that freedom of administrative action is at best an indentured freedom. He must guard closely the number and sorts of loyalties that can place claims on him.

Unwise Trading on Current Problems Can Make the Administrator Into a Broker With Little To Offer in the Way of Futures

The administrator can mortgage his freedom of action even more heavily by practicing a sort of "quid pro quo" administration that places him under obligations to others, both inside and outside the organization. One form of this practice is the acceptance of favors and gifts from those who seek to buy his influence. These administrators finally have no influence because they become panhandlers rather than problem-handlers. Another is the conflict of interest situations, which have been widely publicized in recent years and which the administrator creates by attempting to serve two masters at the same time. More subtle and much more common to the usual administrator are the alliances that naturally encrust administration.

Because administration must depend upon a system of inducements in order to ensure the desired behavior from individuals, it is, in a sense, always trading for support.

This trading takes many forms (including wages, working conditions, and other tangible and intangible benefits), but it essentially means letting the individual have as much of his own wants and ways as is consistent with the behavior desired and the welfare of the enterprise, in return for his specific and general support of the goals of the organization. At higher organizational levels it most often becomes a matter of "scratching your back if you'll scratch mine." This in turn means in effect that the administrator over a period of time creates a number of back-scratching alliances that restrict his freedom and inhibit change. Things often cannot be done because they will disturb the support and doing of other things. Admittedly, some reciprocal back-scratching is required in the administrator's recruitment of effective support, but he must recognize the infirmities of the obligated administrator. Unwise trading on current problems can make him into an administrative broker with little to offer in the way of futures.

The efforts of the administrator to introduce changes into the organization can be checkmated by blockade alignments as well as by his mutual-aid alliances.

Over a period of time the aggressive administrator steps on enough toes as he makes changes to stimulate the formation of mutual protection pacts between various individuals and activities in the organization. These compacts do not call for rebellion but rather for a sort of passive resistance to new ideas and ways. This type of resistance is usually expressed through the sudden support one or more departments start giving to the threatened practices and methods of another department, or through the seemingly unending number of potential problems that another department suggests for review when the change is being discussed, or through the sudden sterility of ideas on how best to implement the proposed change that develops in otherwise highly imaginative and creative individuals within the organization.

At times this passive resistance may be unrealized and unintended. It can come from individuals who ordinarily are the strongest supporters of the administrator. Also, it may represent a discrete incident each time and have no significance otherwise. It does demonstrate that horizontal obligations develop between colleagues in an organization and that these can sometimes be as controlling as the vertical ones that develop up and down the administrative hierarchy. They can be more frustrating to the administrator than the latter because he is not a party to them and cannot be sure as to the scope and intensity of each one. He cannot of course ignore such collateral resistance, but he may be wise not to observe it too strongly unless he can identify direct and positive interests of the recalcitrants that might be adversely affected by the particular change.

Human nature being the ambivalent thing it is, we can act one way and feel the opposite, or support something for one reason and hope we lose for another.

The desire to be a "nice guy" may deter the administrator from making the indicated changes in the organization. The hankering all of us have to be known as a good fellow has been considerably enlarged during recent years by the friendlier-than-thou philosophy of administration that has been preached so strongly to the administrator. It is very difficult, however, to always serve up administrative change with a human relations dressing. Change can be painful and unpopular. It often means applying real pressures to real people. The administrator must remember, however, that he is competing for excellence rather than geniality and that he must cater to a changing environment before he can cater to popularity.

The desire for acceptance is admittedly a valuable quality in the administrator because his success depends upon how strongly the organization seconds his motions. Most often its endorsement of his ideas depends almost wholly upon its endorsement of him. This desire can get out of hand, however, and can damage his administrative effectiveness in two important ways. On the one hand he can become known as a genial fellow who leans over

backward to please. The trouble with leaning over backward is that it marks one an easy pushover, and the administrator may become nothing more than the nice guy he wanted to be. At the other extreme, the hunger for acceptance can weaken, and even destroy, the integrity of the individual. The administrator needs acceptance and ratification, but he must prescribe the moral ground rules by which he will seek the endorsement of those around him.

The extent to which friendship and kinship influence many administrators would probably shock even the administrators who are influenced, if they ever totaled it up.

Patronage and nepotism are usually associated with governmental agencies, but they flourish with equal vigor in a high percentage of all organizations. Some industries, such as fire and liability insurance, apparently obtain the largest part of their volume on a friendship basis. Most family controlled enterprises, and many of the large publicly owned ones, practice a form of administrative featherbedding in which jobs are "found" in the company for friends, and friends of friends. It may well be that prices are just as low from friends and that work performance is just as good from the friends of friends. The essential point is that the use of friendship as the primary specification in any transaction embalms the capacity of the administrator to cope with an unknowable future. He can't turn around when the need arises without turning on his friends unless he leaves himself enough psychological distance in which to make his turn.

Perhaps this "apple a day to keep tension away" philosophy accounts for the reluctance that some administrators have to attempt change. They have been told that people resent and resist change. It would be difficult to show that this has ever been proved as a generalization. In fact, as a generalized statement, the opposite would appear to be true. All advertising studies show the power of the word "new." One only has to review the advertisements to see that more emphasis is given to newness than any other quality.

Reaction to change always seems to be specific and individual. It apparently depends upon the particular change and the personal consequences as seen by each person affected. There is nothing psychopathic about a person who resists something that could leave him worse off. It isn't that he is afraid of change, but rather that he is anxious about what it might do to him. This means that people want to have some notion of what the change involves so that they can measure its personal implications. The fact that they understand the change will not guarantee their approval of it, however.

If the Administrator Doesn't Have Time To Make Needed Changes, He Probably Doesn't Have Time To See That They Are Necessary

Resistance can be expected to prevent some change and to slow the pace of others. There is often a difference, or a lag, in what the administrator would like to do and what the real world around him will allow. But the real world around him can be changed despite its resistance. This is proved by the fact that it does continuously change and it is just those changes that require the administrator to attempt compensating changes. The problem of administration is to engineer this desired change appropriately. This means setting realistic goals for change and packaging it in such a way that it is most acceptable. For change to be acceptable, the goals need to be visible and obtainable and the change attempted must offer improvement and appear worth the trouble.

Old ways do sometimes have the advantage of being the easiest because they are habitual and the surest because they are tried. But these advantages may not be as real as we think. It may be that people often do not change because they are fenced in. In some instances they feel they must act a certain way because they are expected to act that way. Being a Southerner, I have been impressed with the ease with which Southerners accept integration when they come North. There are times people would like to change their ways if they could find an excuse to do so. The administrator must also remember that organizations operate as a totality and that individuals and activities are locked in general step with the whole.

Change is usually difficult and can require much administrative energy and time. An overburdened administrator has little of either to spare. If he doesn't have the time to implement required changes, he probably doesn't have the time to see that they are necessary. Change presupposes evaluation and planning, and these are the least exciting activities of administration. It doesn't compare with the excitement of wrestling with live, jumping problems. It is rather like the difference between the fun of fishing and the drudgery of cleaning the catch. Not only lack of excitement, however, keeps the administrator from getting around to stock-taking. The administrator can become so involved with daily problems that, like a child in the middle of a jump rope, he can't look up.

Neither change nor the evaluation and planning which must precede it are free-time activities. They represent a high priority claim on the time of the administration and the failure to honor this claim can eventually spell administrative bankruptcy. If the daily obligations are so heavy as to preclude adequate time for keeping the organization in step with its environment, the administrator should audit his time and that of his colleagues. The interest he doesn't pay to the changing environment is accumulative and when he finally has to settle he will also find that it was compounded. ■

17 PAGE SPECIAL REPORT

Nursing Home Is at Hospital's Doorstep

Nursing home annex of Fayette County Hospital (in right background) is 100 yards away from its parent hospital.

Operation of a nursing home by general hospital provides continuity of care for patients at low cost

William A. Deems

ALTHOUGH nursing home facilities are a logical extension of a community hospital's health care program, many hospitals still seem hesitant to move in this direction. It's hard to understand why. Certainly the need is there for all in the health field to see. Moreover, such joint operations have generally been successful and have provided a continuity of care that is both reassuring to the community and economical.

For the last four years, for example, we have successfully operated a nursing home facility as a branch of a general hospital. The nursing home, called the Annex, is housed in what was originally a proprietary hospital that was replaced in early 1955 by Fayette County Hospital, a municipal corporation. Fortunately, the Annex is located on the hospital grounds, approximately 100 yards from the general hospital.

Since opening the Annex as a nursing home in 1956, our plan of operation has remained constant and clear: to integrate as closely as possible the staffing and services of the general hospital with the requirements of nursing home patients.

In the Annex, nursing, dietary, housekeeping, plant services, and so forth, are extensions of hospital departments, and are headed by the regular departmental supervisors. Central kitchen facilities for the general hospital are used. Meals are transported in conveyors similar to those used in the hospital. The nurs-

Are Administrators Followers or Leaders?

For a long time I have suspected that hospitals, and especially hospital administrators, are generally followers rather than leaders in community development. A few months ago, at the White House Conference on Aging, I had an opportunity to see this suspicion confirmed – at least in my judgment. In the work group in which I participated, for example, and in informal discussions, there was a dearth of references to community situations outside the hospital in which the hospital had assumed the role of active leadership.

One clear example of this lack of community leadership on the part of hospital executives is found, I think, in their attitude toward nursing homes. Such homes should be encouraged to develop in accordance with good patient care and professional standards – areas in which most, if not all, hospital administrators are experienced and informed. With their background, it seems reasonable to expect administrators to take the initiative in establishing suitable relationships with local nursing homes even if there are obstacles present, as is often the case.

Somebody has to take the first step.

In Illinois, one district assembly of the state hospital association is attempting to do this by encouraging voluntary cooperation between nursing home operators and local hospitals. The district assembly plans to sponsor meetings and round-table discussions with nursing home operators in the region, who will be guests of the hospital administrators. Here are some of the ways meetings of nursing home operators and administrators can be helpful:

Joint demonstrations of new equipment or materials could easily be undertaken. Since most hospitals have inservice training programs, perhaps these could be opened to members of nursing home staffs from time to time. Occupational and physical therapy programs in hospitals could be extended into nursing homes. Hospital dietary departments could, I believe, also assist local nursing homes with menu planning and special diet needs. Purchasing information could also be shared. Most important of all – and most desirable – would be the counseling service that hospitals could provide nursing homes.

Continued interest in the patient after his release from hospital care seems to me to dictate an extension of interest and effort into the nursing home. ■

ing department of the Annex relies on practical nurses and nursing aides. Immediate household supervision is effected through a complement of licensed practical nurses who report directly to the director of nursing services. Graduate nurse supervision is regular and on a scheduled basis and is provided by the director of nurses, and the evening and night house supervisors. Medical care is provided by the regular members of the medical staff of the hospital in the normal patient-physician relationship.

Admissions Are Voluntary

The Annex accommodates 33 patients; its normal occupancy is 95 per cent. Here are some of the rules of operation we have found to be effective:

Patients entering the Annex do so on application – all admissions are, therefore, voluntary. Patients are first admitted to the general hospital for a physical workup, and to establish need, determine if they are suited to the care levels afforded in the Annex, and establish that the patient is compatible with the general patient population. The hospital administrator ultimately decides who will be admitted. Brief, informal, written appraisals are provided by nursing service and physicians as an aid to the administrative office. Once admitted – this is always accomplished in early afternoon to help acclimate the patient before evening meal and bedtime – the staff strives to ensure that the patient is made to feel welcome and familiar with the routines of the home.

William A. Deems has for many years been concerned with care of the aged. As executive director of Fayette County Hospital District, Vandalia, Ill., since 1954, Mr. Deems has also directed the operation of a companion nursing home, the Annex, since 1955. He heads a countywide program devoted to the needs of the aged and, at the state level, serves as a member of the committee on aging of the Illinois Hospital Association. His interest in this field was given further recognition when he was selected as a delegate to the White House Conference on Aging.

Every effort is made to make the patient feel independent as long as he remains compatible. Dependence is elective for the most part, contingent only on the patient's individual requirements and the good of the agency. For example, food service to the bedside is provided only if the patient is unable to use the dining room, and no one enters his room without knocking and receiving an invitation to enter.

While we do not have a complete rehabilitation department, we do have an active occupational therapy program staffed by our hospital auxiliary. Two trained therapists in the auxiliary manage and direct the program. **Spiritual needs of patients are met through the efforts of the Chaplains' Association, another volunteer activity.** Comprised of ordained ministers of the county representing every major church, but responsible to a formal hospital approved discipline, the Chaplains' Association conducts church services regularly in the Annex, and affords counseling service on request.

The rather strict visiting restrictions for the acute hospital are relaxed in the Annex. Children are encouraged to visit and frequently do; Sunday dinners in the home of a child or friend, when medically justified, are looked upon favorably, and the Sunday family drive is encouraged whenever prudent.

Interviews are held at the administrative level with members of the family, and again during the first week between the family and Annex personnel. Special personal habits of the patients are considered and, as

Association Sponsors Good Neighbor Experiment

Early in its existence, the special committee on aging of the Illinois Hospital Association tried to determine what leadership, if indeed any, hospitals could assume locally to provide health care for the aged. Although the committee heard much conversation devoted to this subject around the state, there was a notable lack of actual experimentation. In an effort to correct this, sanction was given to an experiment on a countywide basis. This experiment supported the committee's belief that problems such as care of the aged are best handled locally.

The experiment, called "Project – Good Neighbor," is now in the planning stages. In the county selected, Fayette, a 23 member steering or executive committee has been selected. The committee consists of local leaders chosen for (1) interest in community problems that apply to the aged, (2) vocation, profession or skill, and (3) an expressed willingness to work in the pilot program.

Unlike most such committees, this one does not plan to gather special related statistics before starting the program. The committee is now in the process, however, of assembling a summary of resources available in the community, including information on what these resources can and will provide, and the administrative methods through which their help must be sought.

It is expected that the Good Neighbor organization will consist largely of volunteers, many of whom were recruited from the hospital auxiliary. Before representing the project throughout the county, these volunteers will be given brief but formal instruction in home nursing and the social sciences. They will also be given some training in case detection from the social welfare worker's point of view and a general indoctrination to the purpose of the project. **Their primary task will be case detection: determining the problems encountered by the elderly in each community.**

Once the needs in an individual case are established, the volunteer will try to bring the necessary services or agencies to the patient.

If, for example, there is need for housing, referral will be made to a representative of the building and loan association since there is no housing authority in the county; if there is a need for dietary or nutritional management, the services of the hospital dietitian or a local home economist will be requisitioned.

Perhaps the greatest value of this program is that it demonstrates that the community is interested in caring for its own aged – and so is the local hospital. ■

Table 1 — Standard Staffing Pattern at the Annex

	Full Time	Part Time	Full-time Equivalent
Administration	1	0	1
Male nursing aides	2	0	2
Practical nurses — licensed	5	3	7
Nursing aides	14	2	14
Custodial services (plant)	2	0	2
Housekeeping	2	0	2
Dietary	5	2	6
Total	30	7	34

Top: Between full-time and part-time employes, the ratio of staff to patients in Fayette County Hospital's nursing home is maintained at one to one. Above: All ready for company, the patients await the arrival of visitors in the Annex lobby. Visitors are shared by all, and patients look forward to them.

NURSING HOME HAS

far as practical, the routine work schedule is adjusted to the patient. Food habits and types are also catered to; the dietitian endeavors only to ensure balance and retention within the framework of her planning.

Average stay in the Annex before the patient is released to a custodial care facility or home is 59.2 days. At least once a month the nursing department reviews the care requirements of each patient, and after consultation with the attending physician, the future needs of the patient are determined. We are quick to urge care in other facilities where indicated, and also bring pressures to bear on third parties or family when it is obvious that the patient stays at the Annex as a matter of convenience rather than need.

Current rates in the Annex facility are based on care levels only. They begin at $7 per day and range through $8.50 per day; this compares to a base rate of $14 (day-rate) in the general hospital. Drugs and other services are billed in addition to the daily rate as is done in the general hospital. The average charge to a patient in the Annex is $7.68 per day as compared to a $26.10 charge in the main building.

Staffing for the Annex facility is, of course, lighter than for the acute building, but an over-all ratio of one employe per patient is maintained — these being employes assigned full time to the Annex. (See Table 1.)

As would be expected, and as Table 1 shows in detail, operating expenses of the Annex are much less than comparable expenses of the acute hospital. For the fiscal year

(*Continued on Page* 104)

OCCUPATIONAL THERAPY PROGRAM STAFFED BY HOSPITAL AUXILIARY

Table 2 — How Nursing Home and General Hospital Costs Compare

Operating Expenses of Acute General Hospital and Nursing Home Annex, Fayette County Hospital, Year Ended June 30, 1960

	Employes' Salaries[2]		Supplies and Services		Total		Per Cent of Total[3]	
	Acute	Annex	Acute	Annex	Acute	Annex	Acute	Annex
Administrative and general	$ 40,134[1]	$ —	$ 33,806	$ 573	$ 73,940	$ 573	11.7	0.1
Dietary	25,115	8,343	44,582	15,150	69,697	23,493	11.0	3.7
Housekeeping	12,176	3,605	1,924	390	14,100	3,995	2.2	0.6
Laundry	14,697	—	1,803	603	16,500	603	2.6	0.1
Linen service	—	—	3,848	74	3,848	74	0.6	0.0
Operation of plant	31,332	3,842	38,989	3,904	70,321	7,746	11.1	1.2
Maintenance and repair	—	—	2,423	162	2,423	162	0.4	0.1
Nursing services	153,479	34,626	1,554	6	155,033	34,632	24.5	5.5
Central sterile supply	20,197	—	20,148	4,828	40,345	4,828	6.4	0.8
Motor service	—	—	—	—	—	—	—	—
Oxygen	—	—	3,522	34	3,522	34	0.6	0.0
Anesthesia	8,660	—	2,311	—	10,971	—	1.7	0.0
Medical records	5,103	—	835	138	5,938	138	0.9	0.0
Pharmacy	—	—	19,521	5,924	19,521	5,924	3.1	0.9
X-ray	7,478	—	24,292	—	31,770	—	5.0	0.0
Therapy	—	—	1,996	—	1,996	—	0.3	0.0
Isotopes	—	—	1,140	—	1,140	—	0.2	0.0
Pathology	—	—	7,342	—	7,342	—	1.2	0.0
Cardiology	—	—	2,964	—	2,964	—	0.5	0.0
Laboratory	13,883	—	5,280	29	19,163	29	3.0	0.0
Totals	$332,254	$50,416	$218,280	$31,815	$550,540	$82,233	87.0	13.0
Grand Totals	$382,670		$250,095		$632,773		100%	

[1]Provision for sick leave in amount of $3600 included. [2]Costs rounded off to nearest dollar amount. [3]Percentages rounded off to nearest 1/10th in 1960 figures.

Costs of employes' salaries, supplies and services in the Annex (shaded columns) are significantly lower than they are in the hospital proper. Of the total amount expended for the year ended June 30, 1960, in both units, $82,333 was spent for the operation of the Annex in contrast to $550,540 for the hospital.

The director of nurses of Fayette County Hospital (right) and the supervisor of the Annex, a licensed practical nurse, review nursing problems in the home.

Patients in the nursing home participate in the occupational therapy program. Sessions are held twice weekly under the direction of two trained therapists.

Patients Like the Annex and Don't Want To Leave

(*Continued From Page* 102)

ended June 30, 1960, expenses at the Annex were $82,333; expenses at the acute hospital were $550,540. Salaries for Annex personnel totaled $50,418 while salaries for personnel in the acute hospital totaled $332,259. Supplies and services cost $31,821 for the same period at the Annex and $218,288 at the acute hospital.

The success of the program is perhaps best represented by the frequent comments we receive from patients indicating that they enjoy their stay in the Annex and regret going to other facilities or, indeed, being returned to the general hospital.

As it happens, Fayette County Hospital is a tax-assisted institution — but it seems to me that this fact is unimportant in this instance. Our experience suggests that most hospitals can and should take the initiative in organizing nursing home facilities. Developing a plant and obtaining a staff are problems that can be overcome; all it takes is sincerity of purpose, direction, and intelligent selling to the community. ■

Architect's rendering of the 62 bed prototype nursing home shows provision for exterior court where patients can enjoy a variety of outdoor activities.

Prototype plans for 62 and 44 bed nursing homes are designed to restore long-term patients to maximum self-sufficiency

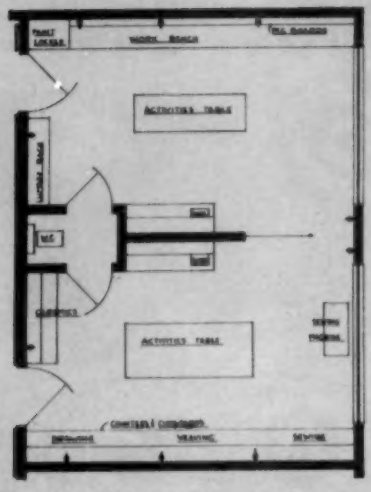
These Nursing Homes Stress Activity

Philip A. Austin

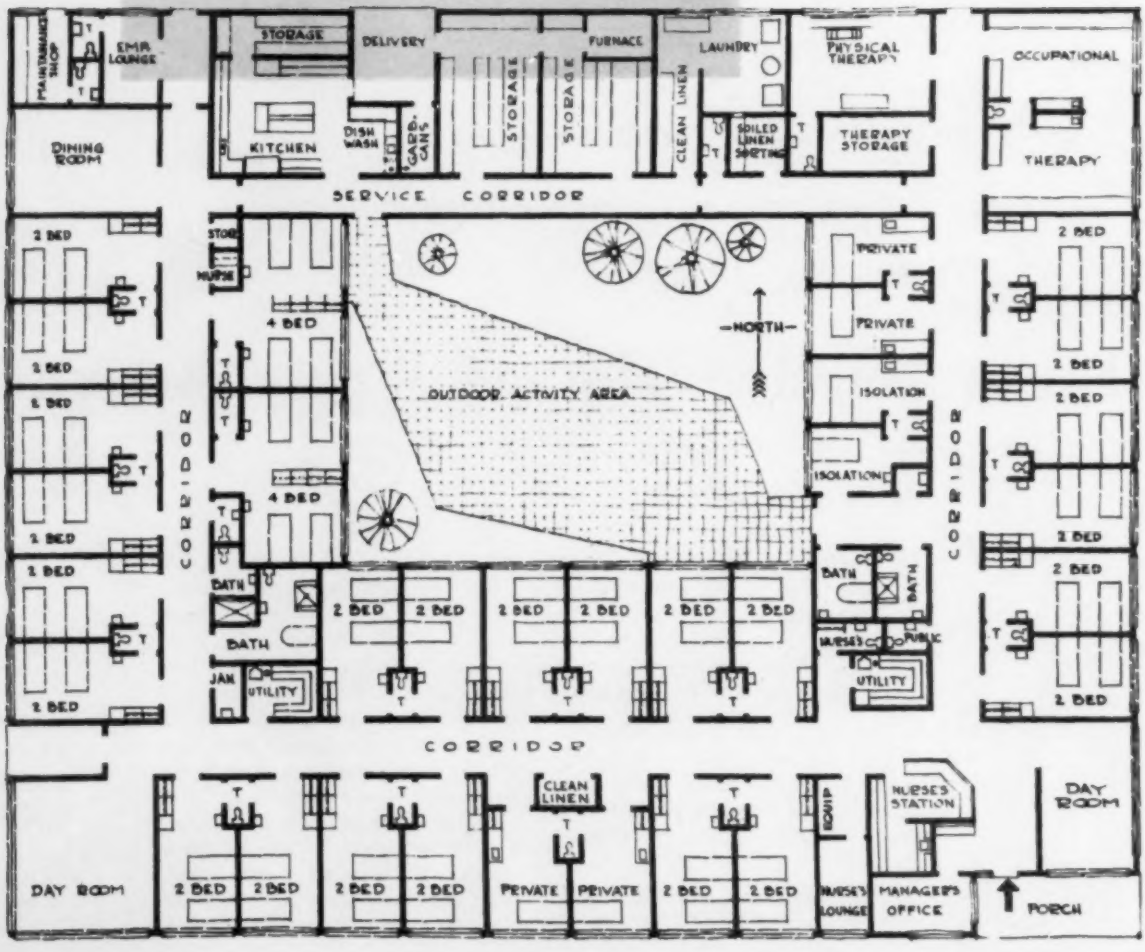
THE primary purpose of a nursing home today is to rehabilitate and restore patients to maximum self-sufficiency rather than to serve simply as a "filing cabinet" where long-term patients live out their last years.

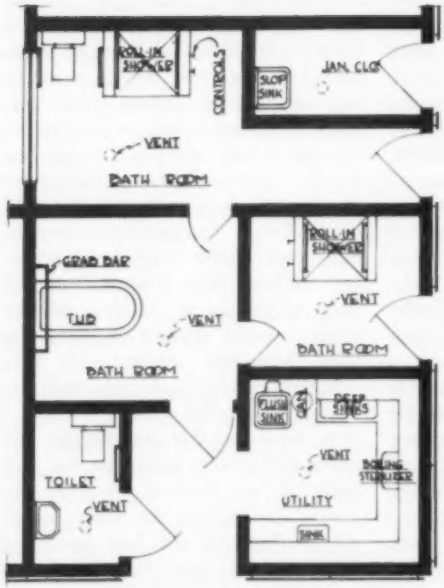
This philosophy is exemplified in the accompanying plans for a 62 bed and a 44 bed nursing home prepared by the Hospital and Nursing Home Section of the Washington State Department of Health. The first plan developed by the department staff in 1954 was for a 27 bed home and was intended simply to show nurse-patient relationships and how they are influenced by the design of the building. Since then the staff has reviewed plans for 68 new homes and 79 major additions providing more than 4000 new nursing home beds. The lessons learned and the valuable suggestions made by nursing home owners in the course of this experience have been incorporated in the improved plans. (*Cont. on next Page*)

Mr. Austin is head of the Hospital and Nursing Home Section, Washington State Department of Health, Seattle.



The occupational therapy room for the proposed 62 bed nursing home is designed to permit expansion when larger rehabilitation unit is added.





In the 44 bed home, the nurses' utility room, with adjacent bath and shower facilities, is situated directly across from the nurses' station. Tubs and showers are designed to meet the special needs of infirm patients.

Sheltered Patios Let Patients Take Part in Outdoor Activities

Plans of the 62 bed (see opposite page) and 44 bed (above) nursing homes developed by the Washington State Department of Health illustrate the planners' philosophy that a nursing home should encourage patients to regain as much independence as possible. In the 62 bed home, provision is made for a sizable outdoor activity area, which can be entered from two corridors. Although the occupational therapy and physical therapy rooms are small, they can easily be expanded if the home is able to provide a complete rehabilitation program that requires more space. In this home, an attempt was made to reduce the concentration of traffic by providing access to all service from two directions. The 44 bed unit is designed on the same principle as the larger home, with provision made for occupational and physical therapy and a combination dayroom and dining room. Architect for both projects was W. H. Gardner of Seattle.

(Text Continued on Next Page)

Charge Nurse Supervises Activities, Which Are Concentrated in One Wing

(*Continued From Page* 107)

The 62 bed home first of all envisions an urban site, where patients can not only watch the passing parade but also can enjoy a variety of pursuits. In addition to the usual outside grounds, this plan provides an interior patio to encourage patients who need protected conditions to spend time outdoors.

The rooms designated as occupational therapy and physical therapy may well be termed activity and exercise rooms. In those homes fortunate enough to have therapists available, these rooms can be used for regular occupational and physical therapy programs. Both rooms are small for complete programs, but their setting allows for future expansion. These areas can be converted into patient rooms when a larger rehabilitation unit is added. Moreover, the therapy suite is designed to be completely flexible. The physical therapy room is free from built-in equipment; instead, portable equipment is used, for which storage space is provided.

O.T. Room Can Be Divided

The occupational therapy room is so arranged that it can be divided to allow two unrelated activities to be carried on at the same time. While projects creating some noise, such as carpentry with power saws, are going on in one section, quiet work such as sewing or weaving can be under way in the other. Toilet areas have been included in both areas.

Adequate nursing service facilities are provided for the care of both bedfast and ambulatory patients. The nurses' station in the 62 bed plan is located so that rooms housing 42 of the patients are directly visible from it. The other 20 beds are planned for the less seriously ill. There is a nursing substation designed not primarily for charting or medicine preparation but as a place where nursing equipment and supplies can be stored.

The preparation of medicine is best done in an area free from interruptions and distractions. Hence the medicine preparation area is shown as an ell behind the nurses' station.

One of the problems inherent in a nursing home is heavy traffic in the areas of concentrated services. In the 62 bed plan an attempt was made to halve the traffic by providing access to all services from two directions.

The manager's office is apart from the nursing unit but in a location that allows observation and direction of visitors. This arrangement should relieve the nurses of much interruption.

Two nursing utility rooms are included to conserve steps in giving patient care. Their locations provide easy access from the corridor while at the same time rooms are shut off from public view. The utility rooms are designed for separation of soiled items from clean ones. Facilities for disposal of wastes and washing of equipment are on one side; on the other are facilities for the storage and handling of clean supplies and equipment. The sterilizer, placed between the two facilities, should be large enough to handle bedside utensils.

A variety of bathing facilities is offered to meet the needs of patients. Island tubs with grab bars encourage the patients' independence and facilitate help by nurses when necessary. One high tub and one low tub provide for different bathing technics. Most of the showers permit bathing of patients seated in waterproof wheel chairs.

Studies have shown that contamination of clean linen by the sorting operation is one of the most serious laundry room problems. In the present plan the danger is materially lessened by convenient handwashing facilities and by the use of walls, doors and an exhaust fan in the soiled linen room designed to maintain sufficient air velocity to minimize the passage of germs into clean areas.

The kitchen is planned for a straight-forward flow of materials from receiving to serving. The use of a scrapping hole leading directly through the counter to the garbage can eliminates handling of the garbage can in the kitchen. The employes' lounge is removed from the kitchen — there is no occasion for employes other than kitchen help to enter that area; thus preparation of food is uninterrupted.

The basic principles followed in designing the 62 bed home have been adapted to a suggested plan for the 44 bed home. This size home is the largest in which the T-shaped circulation pattern can be used effectively. All traffic is routed past the nurses' station. While this arrangement allows for maximum control, it also requires that care be taken to avoid confusion.

In the 44 bed design, as in the larger one, daytime activities are concentrated in one wing, giving the charge nurse control of patients who have entered the wing and also supervision of occupational therapy, physical therapy, and the dayroom. Visitors may reach rehabilitation and recreational areas without passing through the wards, while the bath, utility room, and medicine room are shielded from the main flow of traffic.

Wing Closed Off at Night

Within the activity wing of the 44 bed unit, the kitchen is isolated from the laundry, and direct access is provided from the dining room to the occupational therapy room, permitting the retraining of patients in the use of table service. The opening of the dayroom into the semi-enclosed patio is a feature that should be exploited as activities develop. Since the greatest activity occurs during the day, this arrangement was planned to permit closing off the wing at night without blocking fire exits from the nursing unit, thus enabling evening and night shifts to supervise a smaller area.

A ward suitable for bedfast patients and private rooms for the seriously ill are located close to the nurses' station and the utility room, while additional four-bed rooms for minimum-care patients are at one end of the wing, with private rooms for light-care patients at the other end.

Storage space in both plans is dependent upon the organization of patient care and the policies of the management in regard to patients' retaining their own equipment, such as commodes, wheel chairs and walkers, in their own rooms. ■

The Senate small business committee has plans to raise standards and increase number of nursing homes

New Legislation Will Aid Nursing Homes

Sen. John J. Sparkman

THERE is an excellent opportunity in the field of taxation for Congress to assist small business enterprises generally, including proprietary nursing homes. We have been aware for many years that the burden of taxes has exercised a braking action on the growth of many kinds of small concerns. After the owners of such enterprises mail in their tax checks to the Internal Revenue Service, there is often not enough income left for them to buy needed equipment or otherwise modernize and expand their operations.

Tax Relief Bill Introduced

For this reason, I introduced early in the present session of Congress a small business tax relief bill, S. 2. Its primary purpose is to provide an incentive for small and medium size concerns to expand. My bill would accomplish this objective by permitting a tax allowance for funds reinvested in the business.

Here is the way it would work: A deduction would be authorized from taxable net income in an amount equal to the aggregate addition to capital represented by reinvestment, or plow-back, in depreciable assets, inventory and accounts receivable, except that the maximum deduction would be 20 per cent of net income or $30,000, whichever is the lesser.

All 17 members of the Senate small business committee joined me in co-sponsoring this small business tax relief measure — a measure that can apply to nursing homes.

I also introduced two other tax bills which in my opinion would provide needed benefits to owners and operators of small concerns. One of these bills would make it easier for all taxpayers who wish to provide for their own retirement. The other bill would liberalize the depreciation allowances for those who buy used equipment; for the most part, these are the owners of small concerns. Often proprietary nursing home operators must buy used equipment in order to cut corners on expenses.

After getting off to a somewhat slow start, the small business investment company program is beginning to gather momentum. Authorized by the Small Business Investment Company Act of 1958, this program is designed to make available to small companies long-term and equity capital. I have offered two amendments to this act which I feel will encourage the formation of these investment companies and, thus, further increase the amount of long-term and equity funds available to smaller enterprises.

I believe that the entire small business community has been heartened by the recent increased activity of the Small Business Administration. One of the chief functions of this agency is to make loans to qualified small firms which are not able to borrow on satisfactory terms from their local banks.

Many nursing homes have taken advantage of this S.B.A. lending program. In a recent month, for example, five rest and nursing homes borrowed needed funds from the S.B.A. in amounts ranging from $20,000 to $105,000. Some of these loans were made with the borrower's local bank supplying part of the funds.

S.B.A. also assists in the formation of state and local development companies which are to an increasing degree becoming an additional source of funds for small firms.

Small Business Fostered

On all sides there seems to be a new awareness of the necessity of fostering the small business segment of our economy. Recently I had the opportunity of conferring with President Kennedy on pending small business legislation. I gained the distinct impression that the President and all members of his Administration are keenly interested in supporting and working for an effective small business program, a program which will offer new opportunities to proprietary nursing home operators.

Another field of legislation which can benefit the nursing home business is housing legislation.

In 1959, the Congress for the first time permitted the commissioner of the Federal Housing Administration

to insure mortgages secured by privately owned nursing homes. This program was established after numerous witnesses testified before the housing subcommittee of the Senate committee on banking and currency that funds for the financing of proprietary nursing homes were just not available.

During the housing hearings in 1959, the committee was told that 91 per cent of nursing homes were privately owned; that some 3 per cent were publicly owned, and that some 6 per cent operated under the auspices of nonprofit groups.

We were also told that some 71 per cent of the available beds for caring for the aged and chronically ill are found in proprietary facilities, as compared with 15 per cent in publicly owned facilities, and 14 per cent in nonprofit facilities. We were also told that in spite of the overwhelming predominance of care in the proprietary nursing homes, the problem of mortgage financing was becoming increasingly acute, and that continued efforts to arrange such financing were becoming more and more discouraging.

The committee visualized that properly licensed nursing homes, efficiently operated under reasonable minimum standards, could contribute materially to supplying needed housing to our aging population, particularly to those elderly people who are not completely infirm, but who do need some day-to-day care.

Thus, Section 232 was added to the National Housing Act. It permits the F.H.A. commissioner to insure the mortgage on a nursing home up to 75 per cent of the estimated value of the property. In addition, the new section provided that before such mortgage could be insured under this new program the F.H.A. commissioner must have received from a state agency, designated under Title VI of the Public Health Service Act, a certification that there is a need for the nursing home and that there are in force in the state in which the nursing home is located reasonable minimum standards for licensing and operating nursing homes.

Since this new section to the National Housing Act contemplates the insurance of a mortgage heretofore quite unknown in the operation of the Federal Housing Administration, it was, of course, necessary to implement the law with rules and regulations in order to make the program functional.

Accordingly, a task force committee was established within the F.H.A. for this purpose. This committee was charged not only with the drafting of such rules and regulations as were necessary to make mortgage insurance for nursing homes applicable, but also with studying minimum standards of the several states pertaining to the licensing and operating of nursing homes to determine whether such standards were sufficiently broad to permit the type of certification required by the basic statute.

In respect to the latter, the committee's job was not easy. In some instances, there was an absence of minimum standards. In others, such procedures did not meet the prerequisites contemplated by the new F.H.A. program and, in still other instances, state requirements in this area were far too severe or too complicated to permit the new program to function. In many cases, the committee was able to help the states either establish or adjust their procedures so that the new mortgage insurance program could serve the need for which it was intended. Although the committee worked with deliberate speed, it was not until mid-1960 that the new program became functional.

On Jan. 31, 1961, the F.H.A. had insured four mortgages secured by nursing homes, aggregating some $1,164,200, and the agency had issued commitments to insure 10 mortgages, aggregating some $4,613,900. While it must be admitted that these figures do not show that great strides have been made in meeting the needs of those requiring the type of care offered by privately owned nursing homes, these figures are significant to those who understand the tremendously complex machinery needed to set the program in motion.

As can be understood, the program is still in its infancy. There is no doubt but that as time goes on changes and amendments will be required for the program to serve beneficially the needs of those who require nursing home facilities.

For example, there are those who at present feel that the program should be extended to cover mortgages secured by homes owned and operated by nonprofit groups. These groups were specifically excluded from the 1959 nursing home provision on the premise that such groups were assisted under the Hill-Burton Hospital Construction Act. The Hill-Burton Act, however, permits these grants to such groups which develop the nonprofit and tax-supported hospital facilities. Since this is true, it would appear that perhaps there is a distinction to be made between the nonprofit groups that may participate in the benefits of the Hill-Burton Act and those which at present are eliminated from participation in the Hill-Burton program, as well as the F.H.A. mortgage insurance program.

We seem to have the machinery available to meet the needs of those requiring the facilities and services offered by proprietary nursing homes. I shall certainly continue my support of these programs and I shall continue working toward making these programs serve those who are in need of nursing home care.

I believe that the legislative climate in Washington is such that the aging, the sick, and the crippled can look to a better life through the increasing availability of finely equipped, well operated nursing homes. ■

John J. Sparkman, Democratic candidate for vice president in 1952, has represented Alabama in the U.S. Senate since 1947. As chairman of the small business committee and of the Senate housing subcommittee, Senator Sparkman has been active in developing legislation designed to help increase the number and quality of nursing homes. Recently, he was named chairman of the board of trustees of the International Nursing Home Education, Research and Service Center, which is planned for construction in Washington, D.C.

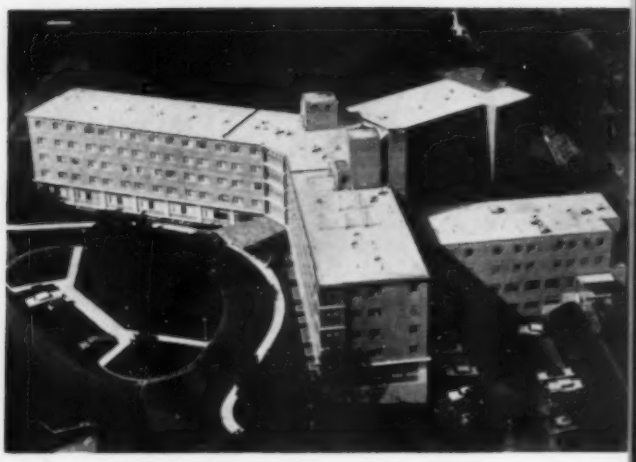
Carmelite Sisters offer formula for happy old age: shelter and security without rules and routines

This Home Takes Aged 'Off the Shelf'

EVERY device the planners could think of to ensure the safety, well-being and happiness of its 300 elderly residents was incorporated into the five-story St. Joseph's Manor, Trumbull, Conn., opened last fall. As the photographs and text on the following two pages indicate, the Carmelite Sisters for the Aged and Infirm, who built and staff the home, have created an environment that encourages their guests "to pursue both old and new hobbies, to participate in activities which are of interest to them, and utilize the facilities with the casualness and friendliness normally associated with family life." Volunteers of all ages help to keep the residents in touch with other generations.

Mother M. Bernadette is administrator of St. Joseph's Manor. Architects were J. G. Phelan Associates, Bridgeport, Conn.

For the guests' safety, handrails line all corridors — even in the lobby.



Right: Five-story St. Joseph's Manor is constructed of reinforced concrete faced with "Old English Pink" brick and limestone trim.

Above: Most residents take their meals in main dining room. Below: The coffee shop, with soda fountain at end, is a pleasant gathering place.

The Living Is Easy and Safe for Residents of St. Joseph's Manor

THREE principal wings and a supplementary unit branch out from the administration area of St. Joseph's Manor at Trumbull, Conn. The first floor of the central section contains the main lobby, administrative offices, visitors' parlors, a large two-story chapel, the main dining room for residents and smaller dining rooms for staff and visitors, plus the large kitchen.

Residents have their choice of single or double rooms — or suites for married couples. Those who need nursing care are housed on the two top floors of the building. Each wing contains solariums, small kitchenettes where residents can prepare between-meal snacks, and small dining rooms for the use of residents who cannot use the main dining room. At the core of each residential floor is a nurses' station equipped with a call system.

Safety and convenience of elderly persons were uppermost in the minds of the designers. The residents don't even have to open the entrance doors, which are operated by electric treadles. Handrails line each corridor wall, thresholds and other tripping hazards have been eliminated, floor tiles are of the nonslip variety, and grab rails are firmly embedded in bathroom walls. Protection against fire has been assured not only by the reinforced concrete construction of the building but also by fire alarm systems and emergency lighting systems installed at critical points. ■

Top: Specially constructed bath chair is provided for residents who cannot use regular tub. Below: Toilets are equipped with side rails and the bathtubs have grab rails for safety.

Right, above: One of the suites for married couples. Suites consist of bedroom, living room, and bath. All living areas for residents are provided with telephone and television.

Right: There is never any shortage of things to do at St. Joseph's. The handicraft room offers facilities for all kinds of hobbies and projects. Volunteers assist with creative activities.

How To Plan and Finance a Nursing Home

A nursing home owner offers tips to prospective nursing home owners on how to: select the right location; establish good relations with county agencies, hospitals and physicians, and organize the home on a businesslike basis

Donald G. Nash

EVERY nursing home, whether it is nonprofit or proprietary, has two basic purposes: (1) to provide the necessary skilled nursing care to its patients and (2) to provide it at a price the patients can pay.

Successful achievement of these purposes requires that the home be soundly organized, financed and constructed. Here are some of the major considerations that must be kept in mind by anyone who proposes to establish a proprietary nursing home.

Selecting the Site

Owing to the nationwide shortage of nursing home beds, the selection of a good location presents few problems. Certain attributes, however, make some locations better than others, and these should be looked for before the site is finally selected: a county seat town, accessibility to hospital facilities, availability of physicians, and an established need for such a home in the community.

In urban areas, especially, a county seat town offers a definite advantage inasmuch as from 50 to 60 per cent of the home's patients will be receiving some form of public assistance. Accessibility to the county agency that provides funds for the care of these patients is of great benefit to the future operation of the nursing home. It is much more satisfactory, and contributes to a better understanding of mutual problems, when the nursing home owner and the county authorities can deal with each other directly instead of conducting negotiations by telephone or correspondence.

A nursing home should never be considered a "para-hospital." It is therefore essential that adequate hospital facilities be easily accessible. The hospital and the nursing home should complement each other and, to be completely effective, there should be close liaison between the administrators of the two institutions. It is important that the nursing home realize its limitations and also that the hospital is made aware of the use that can be made of the nursing home.

It is equally important for the home to have access to a group of well qualified physicians. Almost every nursing home is required by law to admit patients only upon referral by a licensed physician. Hence, the physician is an integral part of the staff and should be available on short notice. The same close working relationship that exists between the nursing home and the hospital should be maintained with the physicians of the area. The doctors should know what services are available in the nursing home so they can utilize the facilities to the best advantage.

The actual need for a nursing home in the community should be given serious consideration. A survey should be made of the beds available in proportion to the population the nursing home will serve. Many authorities consider the often applied ratio of three beds per thousand population completely inadequate.

The increasing use of nursing homes for other than aged clients has increased the demand. A more realistic ratio is five beds per thousand population. For example, a county with a population of 35,000 would indicate the need for 175 nursing home beds. If 150 beds are already available, the chances are that a 25 or 30 bed nursing home would still be needed.

Preliminary Planning

After the location has been settled, the next step is to engage the services of a competent architect on a preliminary basis. Inasmuch as most state health departments require submission of plans prior to construction, it is well to have a preliminary visit with the health department and to present a rough sketch of what is being proposed. Most architects will prepare such sketches for a nominal fee. It is wise to discuss the project with the state health department before embarking upon the building program because it can often provide additional facts and figures that will be helpful in evaluating the merits of the proposed location.

Because of the large investment required in providing a modern nursing home, it is often advantageous,

Mr. Nash is administrator and co-owner of Wahpeton Rehabilitation Center, Wahpeton, N.D.

How Big Should a Nursing Home Be?

ALTHOUGH many factors have a bearing on the size of the home, beginning with the amount of money available for the project, most authorities in the field agree that 40 beds is the minimum for economical operation. Also, the home of 40 beds or over has a better chance of attracting investment capital than does a smaller facility.

There is no saving either in cost of construction or in operation in building a unit as small as 25 beds since the 25 bed facility requires virtually the same service areas and staff as the larger home.

The design of the building should be carefully considered to ensure that the nursing staff can be utilized most efficiently. For example, a 60 bed home housed in a two or three story building would require more than one professional nurse on each shift, whereas the same size facility laid out on a single floor would make it possible to reduce the size of the supervisory staff.

In a home that renders skilled nursing care (which is the type under consideration here), the size of the staff should run about one or two employes (in all categories) per patient for the 24 hour day. In a larger facility, this ratio would be reduced inasmuch as there would be no duplication of domestic staff, such as cleaning, cooking and laundry. Further reduction can be achieved when the home is managed by a husband and wife who live on the premises. In any event, the total staff budget should never exceed 45 per cent of gross income.

if not mandatory, to organize a corporation. This will also increase the possibility of obtaining better financing. As a rule, lending agencies look more favorably upon a loan to a corporation than they do to an individual or partnership.

Many factors must be considered in selection of the members of the corporation. Many corporations are limited to the members of one family; others may be composed of persons who possess certain qualifications that will be useful to the enterprise, *i.e.* an architect, a building contractor, a furniture dealer, or a physician. If there are no specific reasons for choosing the members of the corporation, thought should be given to enlisting successful business people who would not only contribute sound business thinking to the corporation but would also give it prestige.

Planning the Budget

Even before the corporation is formed, it is essential to outline a realistic budget and to estimate the income and expense for an average year to determine whether the project is feasible. If the owner is new to the business, he would have to obtain these costs from other successful nursing homes. The income estimate would have to take into consideration the rate available through the public assistance program, as well as the amount that could be expected from private sources. The estimated income should be figured on not more than 90 per cent occupancy and, preferably, 85 per cent.

If the projected expenses exceed the projected income, it is just as well to forget the whole undertaking.

Costs vary so greatly from one part of the country to another, it is almost impossible to set up a standard budget. The following percentages of expense, however, might be useful in figuring the budget for any part of the country:

Department	Per Cent
Administration	10
Housekeeping	5
Nursing care	30
Dietary	15
Laundry	8
Maintenance and operation	12
	80

The remaining 20 per cent should be set aside for overhead expense and net profit. If salaries are kept as a separate item they should never exceed 45 per cent of the gross income. (Salaries are included in each of the foregoing percentages.)

Financial Planning

Once this projected budget has been prepared and the corporation has been organized, the next thing to consider is the amount of money that must be provided and how it should be raised. The amount will depend to a great extent upon the estimated total cost of the project. In most instances it is highly improbable that a lending institution will provide more than 75 per cent of the total cost; often it will not provide this much. As an illustration, the total estimated cost of a 50 bed nursing home, projected on a per bed cost of $5000, would be $250,000. To this figure should be added $10,000 for working capital. If a lending agency could be interested in supplying 75 per cent of the funds needed, $65,000 would still be required of the stockholders. If the loan amounted to only 60 per cent, the stockholders would be responsible for $104,000. The funds that must be raised directly by the corporation should be procured through sale of stock. This stock sale can be made up of all common or ownership stock, or a combination of

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When a Hospital Starts Emergency Care It Must Provide the Best Service It Can

John F. Horty

WHAT legal duties does a hospital assume when a person presents himself for emergency care and is treated at the hospital?

John F. Horty

In general, once a hospital has taken control of a sick or injured person, or has committed itself to undertake treatment, the hospital has a legal duty to use reasonable care toward the patient. The hospital must provide competent care, with relative promptness, and must assume a reasonable responsibility for any follow-up emergency care required.

In short, when the hospital undertakes to provide emergency care it must do so to the best of its ability.

Reasonable steps on the hospital's part to provide competent care would require that the emergency service be properly organized and staffed. Thus, the hospital must be equipped and able to render any care which would ordinarily fall within the definition of emergency care.

The regulations of the Joint Commission on Accreditation of Hospitals might well be used as the criteria for a properly organized emergency service.

The requirement that treatment be competent also means that if medical care is to be given by a member of the hospital's house staff, that person must be qualified to render emergency care and must render such care in a competent and thorough manner.

This is the third in a series of four articles on emergency care. The previous two articles, which appeared in the February and March issues, dealt with the question of whether the law requires a hospital to provide emergency care for those who seek it. The concluding article in the series will appear next month.

Residents and interns who are unable to understand or communicate with patients in a satisfactory manner should not be permitted to staff an emergency service. The requirement of competent medical care is well illustrated by a 1957 *Florida* case.

A man was brought by the police to a county hospital. He was unconscious. After a cursory examination by an intern, during which no x-rays were taken, he was returned to police custody as a drunk. He died several hours later, death being caused by a chest puncture resulting from several broken ribs.

The court held the hospital legally responsible. The failure to make a thorough, detailed examination of an unconscious patient, unable to speak for himself, compelled the conclusion that there was adequate evidence of negligence in the examination, diagnosis and treatment of the patient.

In the *Florida* case, the question of whether the hospital had a legal duty to render emergency care never arose, because emergency care was undertaken by the hospital. Negligence in rendering care constituted the basis for the hospital's liability.

Certainly, negligence by a hospital employe in providing emergency care, no matter whether the person involved is a nurse, technician, resident or intern, can result in liability to the hospital. Under the general rules of negligence, employers are responsible for the negligence of their employes, and hospitals are no exception to this rule. This would not be true, of course, in those states which grant an immunity from liability to charitable hospitals. However, even in some states where hospitals are granted immunity from liability for negligence of employes, such as *Connecticut, Texas, Washington* and so forth, the selection of an unqualified, untrained or incompetent employe to provide emergency care would result in liability's being placed upon the hospital if the employe performs his duties in a negligent manner.

Not only must emergency care be competent, it also must be reasonably prompt. The most significant characteristic of an emergency service is that medical care is provided with speed when needed. Delay defeats the purpose of emergency care. If delay in treatment, caused by poor organization of the emergency service or insufficient emergency room staff, aggravates the condition of the patient, liability to the hospital may well ensue.

For example, delay in determining what treatment is needed and in setting the wheels in motion so that this treatment is obtained as soon as possible may be considered by a court to be actionable. This might be termed undue delay in providing immediate emergency care. Or, undue delay can occur in starting actual treatment or in continuing it once begun. This might be termed a delay in providing definitive emergency care. Such delay could occur when a summoned physician fails to arrive within a reasonable time or when urgently needed first aid is not given by the nurse, intern or resident on duty. In either instance liability could ensue.

There may be a legal excuse for delay. For example, there is a clear difference between delay caused by inadequate staffing of the emergency service and delay occasioned by a sudden excessive demand on the facilities, such as a fire, tornado or other community disaster. In a disaster, delay in the treatment of any individual would be excused.

What constitutes undue delay will depend on the circumstances of each case. Delaying treatment in one case might constitute negligence and in another case be excused. No firm rule as to how much time constitutes actionable delay can be stated. However, as a general statement, an emergency service should be so organized and staffed that under normal circumstances, at least, care can be commenced within five or 10 minutes after the person presents himself

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These suggested plans for staffing the nursing service will help small hospitals that want to organize, or reorganize, their nursing departments in the interests of better service

Four Nursing Patterns Fit Smaller Hospitals

Fauntella T. Jensen, R.N.

NURSING administration problems in the small community hospital differ significantly from those of the large, highly organized city institution, and it takes a special kind of skill to run the small hospital nursing department.

To the greatest extent possible, the chief nurse[1] should be given a free hand in organizing her department and selecting her staff. Many pressures will be exerted upon both the administration and the chief nurse in regard to the people to be selected. It must be remembered, however, that the success of the nursing department depends to a great extent upon the ability of the nurses to work together without friction, and the possibilities for friction will be reduced if the chief nurse makes her own selections.

The administrator will not be intimately involved with the nursing department heads if the "chain of command" rule is observed as it should be. The chief nurse will be his direct subordinate and all administrative matters will be relayed through her.

In some small hospitals certain divisions of the nursing department have a sort of "understood" exemption from rules which generally apply to other nursing services. This exemption may result from any number of causes but the usual one is privileged immunity on the part of a particular person who holds his job as department head because of peculiar talents needed by the hospital.

For example, the operating room nurse may be the only one available with whom a certain doctor will schedule his operations. Perhaps she has been his scrub nurse for years back and knows all his little whims and fancies. She may be utterly undesirable as a department head and utterly unable to organize and teach subordinates. The hospital cannot afford a full-time registered nurse in the operating room other than as supervisor. Perhaps this nurse is unable to satisfy the other surgeons or to get along with other department heads, the chief nurse – or even her own staff. Nevertheless, because this one surgeon who insists upon having her as his scrub nurse provides 75 per cent of the surgical patients, she is "in" and no one knows what to do about it.

A circumstance like this can be avoided in the beginning by selecting an excellent chief nurse and placing all of the nursing services completely under her supervision. She must have power of decision and the ability to deal with her own staff. She must be more than simply a good nurse. She must be a proven leader.[2]

If a situation already exists that is contrary to good administration but enjoys a certain immunity because of pressures beyond the control of the administrator and chief nurse, there are ways of getting around it. The most practical approach is to request an advisory inspection of the hospital by a recognized and qualified nursing service expert. A list of such experts can easily be obtained from the American Hospital Association or the National League for Nursing.

Following an inspection, and the resulting recommendations, the administration may be able to effect needed changes in an open and acceptable manner without incurring undue criticism, and may even be able to silence accusations of a derogatory nature before they can be made by the offended "dictators."

If a plan for the nursing service – however crude – is already in operation it will be simpler to improve it than to organize and set it up from nothing.

On the following three pages I have outlined four possible plans for setting up a new nursing service or improving a service that is already functioning (pp. 118, 119) and job descriptions for key personnel (p. 120). All four patterns are based on the requirements of a hospital with an average of 25 occupied beds.

(*Continued on Page* 118)

Miss Jensen is owner-administrator of Casa Maria Nursing Home, Tucson, Ariz.

The material presented here is condensed from a manual on nursing service in the small hospital now in preparation by Miss Jensen.

The author wishes to thank Mart Denton, R.N., director of nursing, Sunrise Hospital, Las Vegas, Nev., for her advice and help in the preparation of this material.

[1]Throughout this article, the term "chief nurse" is used to refer to the director of nurses because this designation is generally used in small communities.

[2]Jensen, Fauntella T.: The Chief Nurse in the Small Hospital. New York: Springer Publishing Company, Inc., 1960.

SUGGESTED PATTERNS OF NURSING SERVICE

Plan 1

Personnel Required:

7 a.m.- 3 p.m.	*4 registered nurses (professional)* *3 practical nurses or aides*
3 p.m.-11 p.m.	*2 registered nurses (professional)* *3 practical nurses or aides*
11 p.m.- 7 a.m.	*1 registered nurse (professional)* *2 practical nurses or aides*

Procedures:

One professional nurse acts as head nurse; one serves as medications nurse and assists the head nurse; two other professional nurses take patients for morning care and assist practical nurses as assigned. The patients are assigned by the head nurse in terms of medical need. Each of the two professional nurses who takes assignments has from four to six patients and these are patients who require expert care. The three practical nurses each take from four to six patients of the less critical cases. Each nurse, practical and professional, is responsible for her own patients and charts on the bedside notes. The head nurse and her assistant are responsible for new orders, medications and special treatments.

Evaluation:

This method is preferred in those situations where there is a strong head nurse and relatively weak supporting personnel. It presupposes that the head nurse will be thoroughly grounded in the requirements of the patients and the individual doctors and of the hospital policies in general. It is a somewhat dictatorial sort of administration and, as such, is likely to suffer in the absence of the strong head nurse or her alternate. It also is in disfavor with recently trained nurses who find themselves restricted by the head nurse.

Plan 2

Personnel Required:

7 a.m.- 3 p.m.	*1 ward clerk (It is not necessary that this person have special training. High school graduation and an alert mind are basic qualifications.)* *4 registered nurses (professional)* *3 practical nurses or aides*
3 p.m.-11 p.m.	*2 registered nurses (professional)* *3 practical nurses or aides*
11 p.m.- 7 a.m.	*1 registered nurse (professional)* *2 practical nurses or aides*

Procedures:

This plan is based upon the nurse team method especially adapted to the small hospital. The ward clerk will relieve the head nurse from as many clerical duties as possible (see ward clerk job description). The patients will be divided into three groups and each group will have one registered professional nurse as team leader and one practical nurse or aide. The team leader will be responsible for medications, treatments, charting and orders, and for the care of the most seriously ill patients. The practical nurse will assist her and be responsible for patient care of the less critically ill.

Evaluation:

This is an adaptation of the team nursing method used in larger hospitals. It is the best plan if the hospital budget and the supply of professional nurses are adequate, and if the professional nurse turnover is not critical at times. It permits maximum patient care and head nurse liaison with doctors, visitors and patients, and gives the team leader opportunity for patient contact.

Among the four plans presented on these two pages the small hospital should be able to find one that is suited to its particular needs

Plan 3

Personnel Required:

7 a.m.- 3 p.m.	*3 registered nurses (professional)* *5 practical nurses or aides*
3 p.m.-11 p.m.	*1 registered nurse (professional)* *5 practical nurses or aides*
11 p.m.- 7 a.m.	*1 registered nurse (professional)* *2 practical nurses or aides*

Procedures:

The head nurse acts as general advisor. Each of the two professional nurses acts as team leader with two or three practical nurses or aides under her. The total patient load is equally divided between the teams. The professional nurse is responsible for medications and orders and generally oversees the care of the patients in her group. Each team has one senior and one or two junior aides. The senior nurse or aide divides the work and sets the pace. Each team has permanent work responsibilities on the ward, such as utility room cleaning and supplies, in addition to patient care. The professional nurse has full nursing care responsibility for the patients in her group but does not do bedside care.

Evaluation:

This is an economy plan in terms of personnel. It spreads the professional nursing care and presupposes a well trained, well organized group of nonprofessional nurses. Because so much careful training of the nonprofessional contingent is necessary to offset the professional nurse shortage, a ward secretary to help is highly desirable to give the head nurse time for teaching and other duties.

Plan 4

Personnel Required:

7 a.m.- 3 p.m.	*3 registered nurses (professional)* *1 practical nurse or nurse assistant* *4 aides*
3 p.m.-11 p.m.	*1 registered nurse (professional)* *1 practical nurse or nurse assistant* *4 aides*
11 p.m.- 7 a.m.	*1 registered nurse (professional)* *1 practical nurse* *1 aide*

Procedures:

In this plan the head nurse acts as chief but takes orders and assists generally. One professional nurse acts as medication nurse and one professional nurse acts as charge nurse. The practical nurse or trained nurse assistant is responsible for all treatments and their charting. She is responsible for supplies and generally assists where needed. The medications nurse does medications only and the charge nurse acts as assistant to the head nurse. The charge nurse assigns patients to the aides and accepts direct responsibility for all patient care. This plan also permits of team nursing. Each team would be composed of a junior and senior aide under the direction of a charge nurse.

Evaluation:

This is also an economy plan but is superior to Plan 3 in that it provides a well trained nurse assistant, or practical nurse with special qualifications. If there is a ward secretary and if the professional nurse contingent is superior in terms of teaching, this nurse assistant may be trained from the staff of practical nurses or aides. This plan also makes best use of the professional nurses by the division of professional nursing duties.

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JOB DESCRIPTIONS CLARIFY DUTIES OF NURSING SERVICE PERSONNEL

Professional Nurse (Plans 2, 3, 4)*

1. Receive and give oral report at each change of shift.
2. Check narcotics with off-going and on-coming shift.
3. Make assignments; delegate duties and responsibilities to other members of team.
4. Take and process doctors' orders; call doctor when indicated.
5. Administer, assist with, and supervise and delegate treatments to patients.
6. Administer, pour, order and chart medications for which she is responsible.
7. Plan patient care and welfare utilizing all available knowledge and resources.
8. Teach, guide, interpret to patient, relatives and other nursing personnel as indicated.
9. Take responsibility for charting and correct assembling of chart.
10. Report orally and in writing to, and counsel with, all interested and related personnel, such as doctors, supervisors and head nurses.

*In Plan 1 the head nurse makes her own job descriptions.

Trained Assistant

1. Receive and give oral report to on-coming and off-going shift.
2. Examine and replenish nursing supplies.
3. Assemble and set up all equipment for special treatments for the shift.
4. Check orders or order book for all treatments to be done on the shift. Maintain liaison with professional nurse team leader regarding all treatments to be given.
5. Arrange with other members of nurse team for time and assistance in giving treatments.
6. Administer all treatment; report and chart.
7. Assist with chart desk work, answer telephone, instruct and assist nurse's aides.
8. Be responsible for special observations and care of critically ill patients in liaison with professional nurses.

Ward Clerk

1. Answer telephone.
2. Greet and direct visitors as needed.
3. Assemble and arrange all charts, filling in all data where indicated. Complete and file all charts. Notify nurse in charge when charts are incomplete.
4. Check all doctors' orders, transfer to night order book, and check. See that the nurse in charge has read and checked all new orders.
5. Fill out all laboratory, x-ray, EEG, EKG and other request forms and process them. Fill out and process all diet requests.
6. Chart all temperatures, pulse and respirations, intake and output, and notify nurse in charge of any unusual changes.
7. Order supplies and make all charges.
8. Process all admissions and discharges to ensure that routine work is done. Be responsible for: (a) correctness of clothing lists and pharmacy credits on discharges and for notification of business office in advance of discharges; (b) proper care of patients' valuables and signing of receipt forms for valuables.
9. Take charge of chart desk and table and know location of charts at all times.
10. Make sure all incoming and outgoing material is filed correctly. Be responsible for: (a) receipt and checking of invoices against shipments; (b) correct processing of birth and death certificates, all postmortem requests, and all releases to morticians after checking with nurse in charge.
11. Notify nurse in charge of changes, orders and incidents relative to work.

Practical Nurse or Aide

1. Hear oral report.
2. Take temperatures, pulse and respirations, and record.
3. Take assignments and organize work with team leader or other responsible superior.
4. Prepare patients for meals.
5. Pass and collect trays. Assist patients.
6. Assemble and pass linen and other essentials for morning work, or for evening care only on 3 a.m. to 11 p.m. shift.
7. Check all patients for intake and output needs and report to team leader. Check all drainage bottles and all irrigation set ups for effectiveness and report any stoppages, and changes needed to team leader.
8. Check any suction apparatus and oxygen or other special equipment for proper function; report observations to team leader.
9. Admit patients, list clothing, note any pertinent facts, and report. Take temperature, pulse, respiration and blood pressures.
10. Give enemas as assigned and give morning or evening care, including baths.
11. Answer patients' call signals.
12. Keep patients' water pitchers supplied and bedside tables neat. Pass midmorning or evening nourishments or drinks as indicated.
13. Discharge patients as instructed.
14. Give bedside care to patients as assigned and report on patients to team leader.
15. Attend to special assignments as indicated.

ABOUT PEOPLE

Administrators

David Babnew Jr., Ph.D., has been appointed superintendent of hospitals of the city of Tampa, Fla. He was formerly administrator of Northampton-Accomack Memorial Hospital, Nassawadox, Va. Mr. Babnew is a graduate of the University of Pennsylvania and is a member of the American College of Hospital Administrators.

Donald E. Walchenbach has been appointed director of Hurley Hospital, Flint, Mich., succeeding **Stephen A. Lott,** who will become administrator of Battle Creek Community Hospital, Battle Creek, Mich. Mr. Walchenbach was formerly assistant director of Butterworth Hospital, Flint. He received his bachelor's degree from Hope College, Holland, Mich., and a master's degree in hospital administration from Columbia University.

D. Walchenbach

Dr. John P. Bachman has been appointed superintendent and medical director of Cedarcrest Hospital, Newington, Conn. He is presently superintendent of Seaside Hospital, Waterford, Conn. Dr. Bachman succeeds **Dr. Reginald C. Edison,** who has recently been named deputy commissioner by the state Council on Tuberculosis Control, Hospital Care, and Rehabilitation.

William S. Atkinson has been appointed administrator of Piqua Memorial Hospital, Piqua, Ohio. He is a graduate of the program in hospital administration, University of Michigan, and was formerly the assistant administrator of Crittenton General Hospital, Detroit.

Damon D. King is the new administrator of Walton County Hospital, Monroe, Ga. He fills the position left vacant by **Ewing Barnett,** who resigned to become administrator of the new R. T. Jones Memorial Hospital, Canton, Ga.

Jesse H. Bartlett has resigned as administrator of Boone County Hospital, Columbia, Mo.

Walter R. Brungard Jr. has accepted the position of administrator of Blanchard Valley Hospital, Findlay, Ohio. He received his master's degree in hospital administration from the State University of Iowa and has served as assistant administrator of St. Luke's Hospital, Davenport, Iowa, and Theda Clark Memorial Hospital, Neenah, Wis.

P. David Youngdahl is the new administrator of Frederick Memorial Hospital, Frederick, Md., succeeding **Ethel Northam,** who retired. Mr. Youngdahl has a master's degree in hospital administration from the University of Minnesota.

Aldine A. Rosser has resigned as administrator of Warren A. Chandler Hospital, Savannah, Ga., to become administrator of Kennestone Hospital, Marietta, Ga. Mr. Rosser is a past president and trustee of the Georgia Hospital Association.

Tom B. Little, administrator, Hominy City Hospital, Hominy, Okla., has been named administrator for the new Haskell County Hospital, Stigler, Okla.

Clayton Alexander was recently appointed administrator of Burke County Hospital, Waynesboro, Ga. He is a graduate of the course in hospital administration at Georgia State College.

Don Welch, former administrator of Hialeah Hospital, Hialeah, Fla., has been named administrator of the Florida Sanitarium and Hospital, Orlando, succeeding **C. P. Hardin,** who has retired.

Dean R. Upson has resigned as administrator of Shelby Memorial Hospital, Alabaster, Ala. **Lois Looney** is acting administrator.

Henry S. Rogers, administrator at Memorial Hospital, Sedro Woolley, Wash., has resigned to become administrator of Olympic Memorial Hospital, Port Angeles, Wash.

F. Leonard Gibson has been appointed administrator of the new Lincoln Hospital, Toledo, Ore. He is a graduate of the program in hospital administration at Northwestern University.

M. J. Foerster has been named administrator of Bingham Memorial Hospital, Blackfoot, Idaho.

Sister Dorothy Reece, S.G.M., has been named administrator of St. Peter's General Hospital, New Brunswick, N.J., succeeding **Sister Georgette Leduc,** who is now provincial superior of the Grey Nuns of Montreal in the United States.

Phil Carter has been appointed administrator of Carrie Tingley Hospital for Crippled Children, Truth or Consequences, N.M. He formerly was administrator of Methodist Hospital, Lubbock, Tex. **Marvin Hunter,** assistant administrator at Methodist, has been named acting administrator.

Paul Serz has been named administrator of the new Concho County Hospital, Eden, Tex.

Donald Shepard has been named administrator of Marlette Community Hospital, Marlette, Mich., succeeding **Jack Croes,** who resigned. Mr. Shepard was previously assistant administrator of Central Michigan Community Hospital, Mount Pleasant.

Keith Calvert has been named administrator at Oklahoma General Hospital, Clinton, Okla. **Kelley Davis** has succeeded Mr. Calvert as administrator of the Okfuskee County Memorial Hospital, Okemah, Okla.

Hazel Dahl, R.N., has been named superintendent of Mount Linton Hospital, Metaline Falls, Wash., succeeding **Doris Underwood,** who resigned.

Donald E. Nelson is the new administrator at Mizell Memorial Hospital, Opp, Ala., succeeding **W. H. Brogden,** who is now administrator at Columbia General Hospital, Andalusia, Ala.

Warren Croston is the new administrator for Southern Coos General Hospital, Bandon, Ore.

Morris Henderson has been named administrator of People's Hospital, St. Louis. He has been acting administrator since last May.

Pleas M. Walker has been named administrator of Adams Hospital, Panama City, Fla., succeeding **Dottie Thomas.**

Robert Benthall has been appointed administrator of Brenham Milroy Hospital, Brenham, Tex. Mr. Benthall was formerly purchasing agent of Medical Center Hospital, Tyler, Tex.

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Two Hospitals May Do Better Than One in Educating Interns and Residents

Lyle Hay, M.D.,
Warren Rutherford, and
Robert W. Bachmeyer

IN A period when the number of graduates from medical schools has remained relatively constant to the increasing number of hospital beds, much consideration has been given to the method of attracting medical graduates to the voluntary nongovernmental hospital. Hospitals that appreciate the service which an internship and residency program provides must realize that to obtain competent doctors they must develop a well balanced educational program. The immediate problem is how to develop most economically a comprehensive program that can support active well qualified directors and provide the type of training necessary for the full development of the intern and resident. Once this has been accomplished, it should be possible to attract more and better qualified graduates.

At the Swedish and St. Barnabas hospitals in Minneapolis, we have arrived at what we think is a sound realistic approach to improvement of house staff training and our hospitals' service. We do not contend that this solution will work in every situation but it has considerably improved our own program.

The Swedish and St. Barnabas hospitals are general acute, voluntary, nongovernmental hospitals of 505 and 384 beds, respectively, with an average occupancy of 72.3 per cent. St. Barnabas is affiliated with the Episcopal church while Swedish, although not formally affiliated, is closely allied to the Lutheran churches in the area. The hospitals are adjacent to one another. Combined, they provide 241,000 patient days of care each year and have 304 doctors on their active staffs.

Development and Organization

A group of four hospitals in Minneapolis, feeling the pressure of mutual problems within their medical education programs, joined to discuss them and to find ways to improve their programs. Meetings were held with representatives of the medical staffs and administrators from each hospital. From these meetings in 1955 came many of the ideas which were incorporated into the Joint Medical Education Program at the hospitals begun on July 1, 1959.

Prior to the recent reorganization each hospital had conducted its own independent medical education program. At St. Barnabas responsibility was given to a proctor within each specialty to supervise the training given the interns and residents in his specialty. Under the old program the proctor had complete responsibility for the organization and management of his section and the supervision of the house staff assigned to it, as well as the teaching provided. Teaching was done by members of the hospital staff both in the hospital and in their offices but this system left much to be desired in terms of continuity and coordination. Under this program we found it difficult to attract American medical school graduates and to maintain approval by the A.M.A.'s Council on Medical Education and Hospitals and by the related specialties.

After provisional approval by the trustees and medical staffs of both hospitals and as a result of a meeting called to consider the problem, the following pattern of organization was developed.

Control of the joint program rests with a joint council for medical education consisting of the administrator, at least two members of the board of trustees, and at least three members of the medical staff from each hospital. The representatives from the medical staffs are nominated by the executive committee of each staff and include an internist, a general practitioner, and a general surgeon.

(*Continued on Page* 124)

The official title of the program discussed in this paper is "The Joint Medical Education Program of St. Barnabas and Swedish Hospitals."

arresting measure for surgical bleeding

When the customary surgical techniques for capillary hemostasis fail, prompt cessation of oozing may usually be obtained with OXYCEL (oxidized cellulose, Parke-Davis). This absorbable hemostatic conforms readily to all wound areas...assures a clear operating field...helps to shorten operative procedures.

Available in forms for every need: OXYCEL (oxidized cellulose, Parke-Davis). Pledgets (Cotton-type), $2\frac{1}{4}$ in. x 1 in. x 1 in.; Pads (Gauze-type) (8-ply), 3 in. x 3 in. and 4 in. x 12 in.; Strips (Gauze-type) (4-ply), 5 in. x $\frac{1}{2}$ in., 18 in. x 2 in., 36 in. x $\frac{1}{2}$ in., and 3 yd. x 2 in.; Foley cones (Gauze-type) (4-ply), 5 in. and 7 in. diameters. Sterile as supplied.

Indications: As an adjunct to effect hemostasis in bleeding associated with capillary oozing. ***Use:*** Strips—temporary packing of bleeding cavities, nasal passages, and tooth sockets; pads—temporary packing of surgical beds as after biopsies and to cover more or less extensive areas as in laparotomies; pledgets—in neurosurgery and in dental work for small localized bleeding areas; Foley cones—in prostatectomy.

Precaution: Excess amounts should be removed prior to surgical closure to avoid foreign-body reaction. Not to be used in sites of infection or following silver nitrate or other escharotic chemical agents. Contraindicated in clean bone surgery when poor vascularization is present and in instances where rapid callus formation is desired. Should be used sparingly in open reduction of fractures and in cancellous bone. Will not withstand heat sterilization. Remove from container aseptically.

FEB. 1961 (P 344)

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

absorbable hemostatic

OXYCEL

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The council's main duties involve the selection of competent directors, the development of major policies, and the defining of interrelationships including the distribution of costs and the utilization of common facilities. This group meets quarterly to conduct its activities.

The council was fortunate in being able to retain a full-time experienced coordinator, board-certified in surgery, to whom was delegated the over-all responsibility for the joint program. In addition to these responsibilities he has been appointed director of intern and resident training in surgery for both hospitals. In actual operation, he then assumes primary control for all teaching and supervision given medical graduates within the specialty of surgery and develops independently the program for that section. As coordinator, however, he counsels with the co-directors and proctors in the other major sections within each hospital in planning their programs. He thus assures that adequate training and experience are being given in each section and that these individual programs, when combined, provide a total comprehensive learning experience for all those who participate.

Coordinator Screens Applicants

Another, and by no means minor, responsibility of the coordinator is that of attracting and selecting interns and residents under the joint programs. This includes the preparation and distribution of printed material, as well as interviewing all applicants and making the ultimate assignment to specialty and hospital of primary interest to the graduate.

Although service patients are the assigned responsibility of the proctor of the particular service involved, the coordinator assumes ultimate responsibility for all the care provided within the hospitals by the intern and resident staffs. Any other aspect of the training program, including housing, remuneration and scheduling, are similarly within his area of administrative responsibility.

With total responsibility for the program the coordinator has been delegated such authority as may be necessary to fulfill these responsibilities, limited only by budgetary and policy restrictions established by the joint council. This includes authority to assign, hire or dismiss house staff when ratified by the council, pay all expenses accruing to the program, expend funds accumulated from medical fees paid to the teaching service, establish procedures to assure adequate house staff coverage on the services, and make the final decision regarding the admission, treatment or discharge of all service patients.

Co-Directors Were Appointed

To ensure adequate supervision it was deemed necessary to acquire a director for the section of medicine. In lieu of a single full-time director, however, co-directors were appointed. Each devotes half of his time to teaching totally within his own hospital of primary affiliation. Thus each independently assumes responsibility for the program in medicine within his hospital and relies on the coordinator for assuring uniformity in the programs. The co-directors also work jointly with the coordinator in developing lectures and conferences attended by members of both house staffs for their own and all other sections within the joint program. A combined weekly conference and lecture schedule is followed that brings together members of both house staffs for regular instruction. It should be noted that the liability for the salary of both the coordinator and co-directors of the program is shared equally between the two hospitals.

Proctors Volunteer

The remaining sections not covered by a salaried director are supervised on a voluntary basis by board-certified proctors selected by the chiefs of these sections within each hospital. Like the co-directors in medicine these proctors direct the activities of interns and residents within their section independently of the proctor in the same section in the other hospital. All teaching activities, including the care and treatment of teaching service patients in that section, are their delegated responsibilities. Now, however, each proctor places reliance upon the coordinator for long-term planning, over-all administration, and organizational matters associated with the program and the house staff. Interns and residents in a given section practice solely within one of the hospitals and therefore are responsible only to the proctor within that hospital and the coordinator of the program.

The medical staffs of both hospitals have given full support to the joint program by participating in lectures and meetings, allowing well supervised interns and residents to participate in the private care of their patients, and referring sufficient numbers of patients to the teaching service. During the first six months of operation patients were referred from 85 members of the combined staffs of both hospitals, the total be-

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Over-all responsibility for the joint educational program for interns and residents at St. Barnabas and Swedish hospitals, described in this article, was delegated to Dr. Lyle Hay in 1959. *Dr. Hay has remained true to his home state of Minnesota in his choice of college (University of Minnesota), medical school (same), and staff appointments (Veterans Administration, Mount Sinai, St. Barnabas, and Swedish — all in Minneapolis). Co-authors with Dr. Hay are Warren Rutherford and Robert W. Bachmeyer. Mr. Rutherford is serving a one-year administrative residency at St. Barnabas to complete requirements for his M.S. in hospital administration at the University of Minnesota. Mr. Bachmeyer is director of St. Barnabas Hospital and a member of the faculty of the Minnesota course in hospital administration. He has been a regent of the A.C.H.A. since* 1957.

Dr. Hay

Mr. Rutherford

Mr. Bachmeyer

Expenses of this joint program can be divided in proportion to the benefits each hospital receives

ing divided equally between the two staffs. Since that time the teaching service has continued to grow, thus demonstrating the medical staffs' confidence in this program. Any other objective evaluation at this time would be premature except to report that we have already received requests for applications to this program from 30 American graduates.

Reference has been made to teaching service patients. Individual responsibility for the treatment of patients greatly enhances the experience an intern or resident receives. This experience is more valuable with good supervision and teaching, which also decreases the legal risk of the hospital. Through the joint program continuing and adequate supervision is possible. Each hospital has committed itself to make available 3 per cent of its beds for teaching. It is understood that this 3 per cent allocation shall not include any patients for whom other staff doctors retain responsibility or any chronic disease patients who have limited value as teaching material. Once they have been referred to the teaching program these patients become the joint responsibility of the intern, the resident, and the member of the teaching staff who is responsible for that particular section.

Advantages of the Program

What are the advantages of a joint educational program?

To be assured of continued approval of our internship and residency program and to be able to attract higher caliber interns and residents to our institutions, adequate direction of our medical education program was vital.

Through the joint effort of two hospitals exceptional leadership and direction has been procured through the acquisition of a well qualified coordinator, on an equal cost basis shared between the hospitals at a realistic cost to each.

The staffs of the two hospitals increase in quantity and quality the pool from which we can draw doctors for teaching assistance through lectures and individual instruction.

The combined number of patients admitted to each hospital assures adequate quantities and varieties of conditions to be used as teaching material both in bedside rounds and in conferences attended by the combined group of interns and residents.

The two hospitals combined include a wide variety of treatment facilities and equipment which one hospital because of the limitations of size or program may not be able to make available to the intern and resident.

Sharing the program's operating costs reduces the over-all cost to each hospital but nonetheless provides the intern and resident with all the educational benefits and opportunities that are available in individual hospitals of much greater size.

The more efficient utilization of medical libraries and classroom space in both institutions assures the availability of a wider variety of publications and adequate physical facilities whenever they are required for instruction.

At present, outpatient facilities are utilized within each hospital, with responsibility given to the interns and residents affiliated with that hospital and their proctor or section director. There is no joint control except through the supervision of the program coordinator. However, the establishment of a joint outpatient clinic is considered as a logical extension of this program.

Facilities for teaching, including laboratories, are provided on substantially an equal basis. Costs of office and clerical services needed for operation of the program and any other expenses incurred are distributed on a 50-50 basis. Only those expenses attributed directly to the individual intern or to the total house staff assigned to each hospital are paid individually by that hospital. This would include stipends, housing costs, meals, laundry and the teaching service write-offs within the individual hospital. It is important to note, however, that the policies covering the aforementioned items are mutually developed and nearly identical.

St. Barnabas Hospital's share of the joint program expense for the last year was $24,000. This total includes one hospital's share of the coordinator's and co-director's salaries, the salary of a secretary, publicity, clerical supplies, and other miscellaneous joint expenses. From figures available, it is apparent that if the program were not conducted under such a combined cooperative arrangement an additional outlay of $14,000 would have been required.

As administrative costs are shared equally, so is any revenue which might accrue to the joint program. A bank account has been opened in the name of the Joint Council to receive any funds in its behalf and is thereafter administered by the Joint Council as it sees fit.

As has been mentioned, the hospitals have joined administratively but they do not lose their individuality where the intern and resident are concerned. Each hospital participates jointly in the intern matching program under the name of the Joint Program, but once interns and residents are selected they are assigned to the house staff of either of the two hospitals. By this means the expenses of the program can be divided in proportion to the benefits which each hospital receives and, since the graduate becomes better acquainted with the hospital and medical staff, individual instruction is improved.

Costs of publicizing the program are shared equally; hence methods used in attracting competent medical graduates can be utilized on a larger scale but at a lower net cost to the individual hospital.

It is our contention that by increasing the size of the unit for which the program exists we can broaden the scope of our educational activity. We thereby improve the quality of training given in our institutions, with resulting higher quality of care for our patients — and it is all done as economically as possible. ■

EXCISION OF PATHOLOGICAL DISC, AND FUSION

Radiographs on Kodak Blue Brand Medical X-ray Film; surgery photographed on Kodak Ektachrome Film

PROBLEM: Disabling left neck, left shoulder and arm pain for considerable period. No significant abnormality, no definite nerve root deficit in evidence. No response to usual conservative measures.

What the radiologist saw—what the surgeon did.
Figures 1-2: Radiologist reported no significant abnormality in preoperative radiograph and myelograms of cervical region. **Figure 3:** Incision in left side of neck.

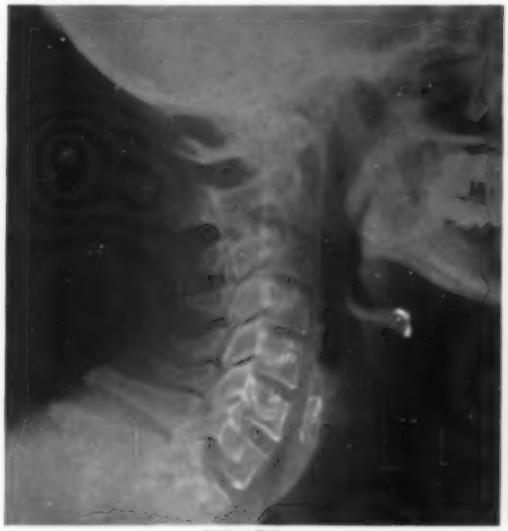

FIGURE 1

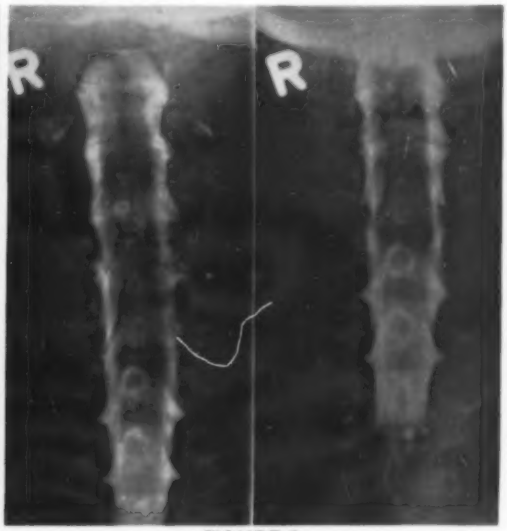

FIGURE 2

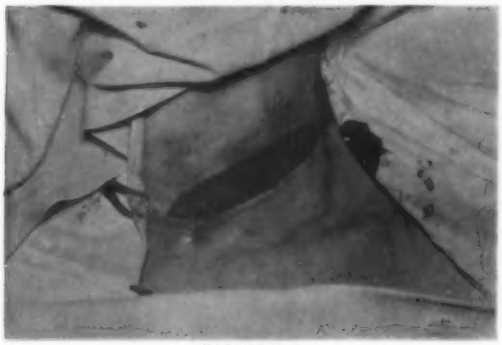

FIGURE 3

FIGURE 4

FIGURE 5

Figure 4: Exposure of vertebral column, sternocleidomastoid muscle and carotid sheath below and to the right; thyroid, trachea and esophagus above and to the left.

Figure 5: Insertion of needles for discogram. (Turn page for result.)

Note: Radiographs and photographs such as those reproduced here have many uses. They are invaluable to illustrate talks, lectures, classroom discussions. From original transparencies, black-and-white or color prints may be made to illustrate displays, articles for publication. And—remember always: The photographs you make today may be used tomorrow—years from now.

EXCISION OF PATHOLOGICAL DISC, AND FUSION (Continued)

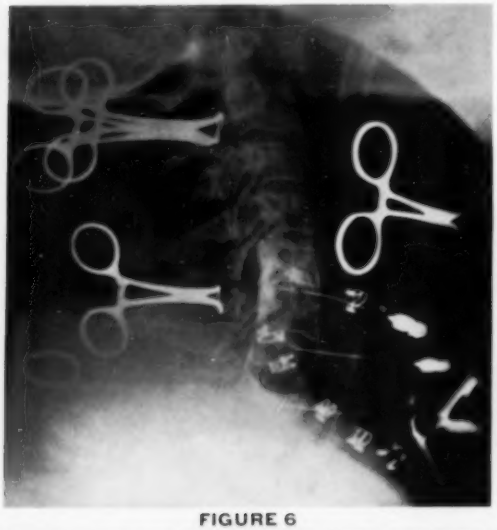

FIGURE 6

Consider carefully the color photographs shown here. How significantly—objectively—they support the printed word. How vividly color defines tissue areas . . . clarifies the descriptive matter. Yet the cost of this material is small in terms of the aid it gives in teaching and research projects.

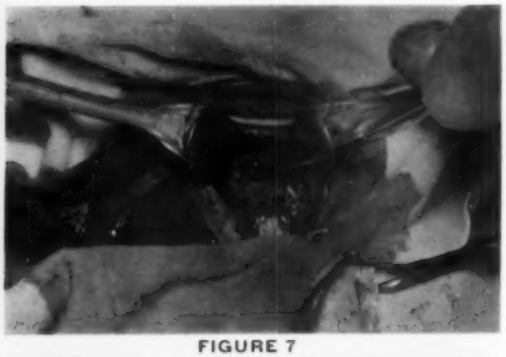

FIGURE 7

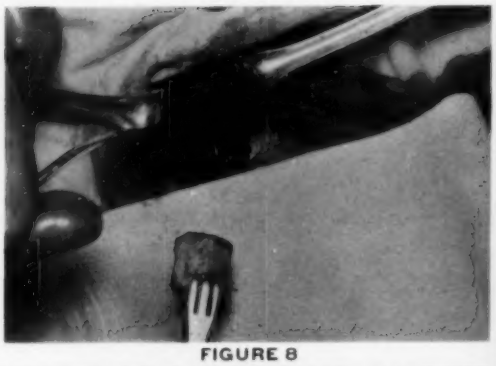

FIGURE 8

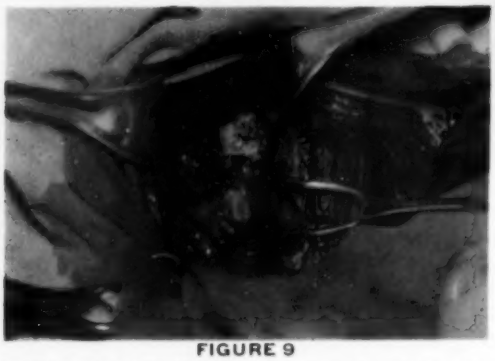

FIGURE 9

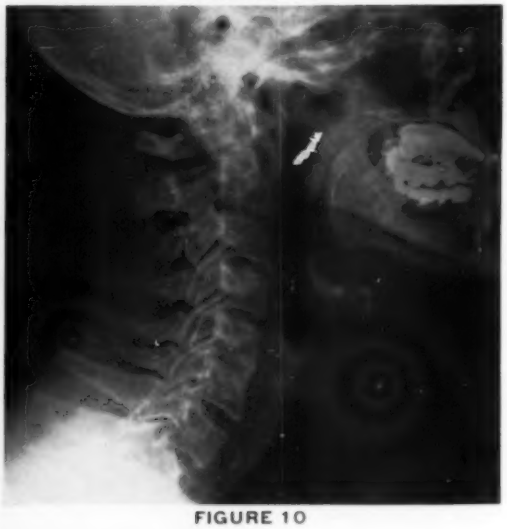

FIGURE 10

Figure 6: Discogram shows leakage of contrast medium posterior to bodies of C5 and C6. **Figure 7:** Excision of disc between C5 and C6. **Figure 8:** Bone graft from the right iliac crest shaped to fit disc space. **Figure 9:** Bone graft wedged into place between vertebral bodies of C5 and C6. **Figure 10:** Postoperative radiograph shows bone wedge in place.

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Ten-Point Review Can Reduce Costs of Operating Pharmacy

By Grover Bowles Jr.

INCREASED pharmacy volume resulting from the availability and use of more and better drugs has offset rising pharmacy operating costs during recent years. While this is a healthy and even fortunate situation, good management demands that all operating procedures be frequently reviewed to keep costs at a minimum.

To a large degree, payroll and inventory costs have been responsible for the gradual increasing cost of operating the hospital pharmacy. Pharmacists' salaries, while still very reasonable compared to those of other professionals, have increased steadily during the last two decades. In dollars the pharmacy inventory has expanded rapidly since the introduction of penicillin in the mid-Forties. These, then, are two important areas that should be watched closely if operating costs are to be kept reasonable.

Perhaps these suggestions will be helpful:

1. Keep pharmacists practicing pharmacy. There have never been enough well trained hospital pharmacists to go around, and there is no reason to believe that this situation will change during the years ahead. Yet too many highly skilled pharmacists reduce their productivity by doing routine nonpharmaceutical procedures, such as clerical work that might be better performed by others.

2. Keep pharmaceutical service available when needed. Are pharmacists scheduled according to the demands of the department or according to their own personal convenience?

3. Constantly look for better ways of doing things. Traditionally the pharmacy is the least mechanized department of the hospital. As another method of extending the pharmacist's productivity, investigate the use of semi-automatic tablet counters, automatic pipetting machines, and other labor saving devices.

4. Use time and motion studies to develop the best arrangement for shelving, refrigerators, sinks, counters and other work areas. Minimize time and effort to carry out routine functions.

5. Analyze the cost to prepare all items compounded in the pharmacy that are commercially available. Be sure that your cost to prepare is less than the cost to obtain the product from a reputable firm. The pharmacist's time and other nondirect costs must be included in the cost to prepare items in the pharmacy.

6. Improve your housekeeping. "Have a place for everything, and everything in its place." This saves valuable time. Remember a clean department gets cleaner and a dirty department gets dirtier.

7. Simplify paper work. Discontinue all unnecessary records and reports. Use printed forms to save time and avoid errors. Pay particular attention to filing. Keep files active by filing only the essential and discarding material that has outlived its usefulness.

8. Critically evaluate your present inventory control methods. Good inventory records ensure proper turnover, protect against overstocking, and keep costly emergency orders to a minimum. A good inventory control system provides for the return of slow moving items before they become obsolete.

9. Make a careful study of your supply sources. Are you taking full advantage of quantity purchasing, hospital packages, and hospital prices? Are there specific advantages to buying direct, or can the same items at the same prices be obtained locally?

10. Review your pharmacy charges frequently. Are they fair and just to all and explainable to any reasonable person? ■

A Discharge Summary Can Save Time for Physician and Hospital

By Robert S. Myers, M.D.

WHAT does the busy physician first look for when he examines the medical record of a patient who has been readmitted to the hospital? The discharge summary; for this, if properly written, gives him quickly and clearly the story of the patient's previous illness. It saves him a considerable amount of time and effort that he otherwise would have to spend in reading the entire record.

Dr. Robert S. Myers

But the discharge summary serves several other equally useful purposes: A copy sent to the referring physician informs him of the patient's illness, the treatment given, and his response to therapy; a copy given to the attending physician is part of his office record for that patient; a copy to the intern or resident who participated in the care of the patient serves as a permanent record of the patients he has seen or the operations he has done; the information in the hospital's copy permits the hospital quickly and accurately to complete the many insurance forms submitted to verify the patient's illness and its treatment.

An additional and novel use of the discharge summary has been in effect for many years at the University of Alberta Hospital, Edmonton, which, since 1922, has kept a separate file of discharge summaries. These are used frequently by the medical staff to conduct preliminary surveys to determine whether the patients' complete medical records should be obtained for definitive study in clinical research.

To fulfill all of these valuable functions properly, the discharge summary should observe the following essentials:

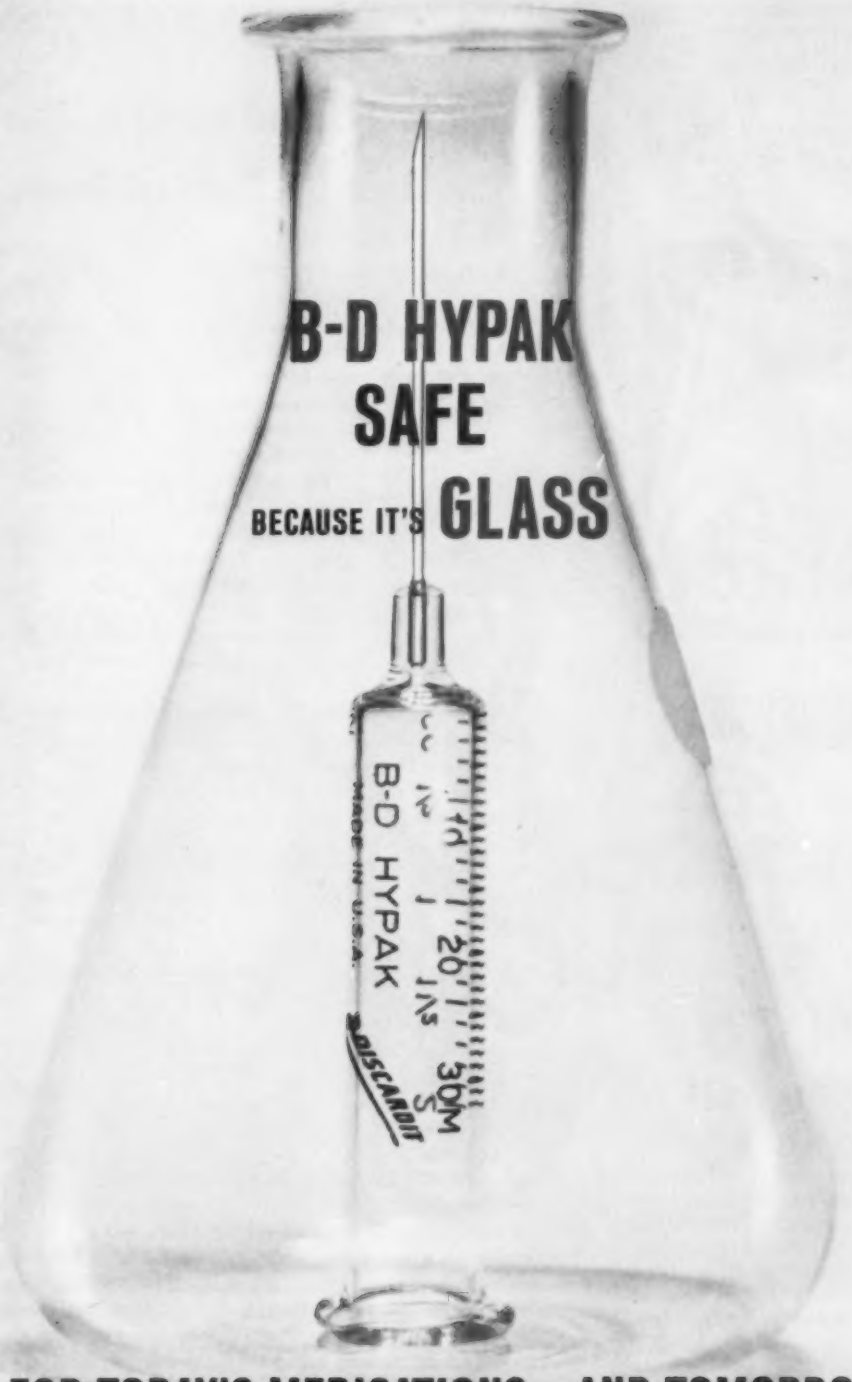
1. It should be concise, rarely more than one typewritten, single-spaced page, and usually it can be completed adequately in less space.

2. It should contain only the essential facts of the patient's illness, investigation, treatment and its results.

3. It should be dictated promptly upon discharge of the patient, while the details of the patient's illness are fresh in the physician's mind.

4. It should conclude with the following precise information: final diagnosis, operation, if any, condition on discharge, and the disposal of the patient, *i.e.* was he returned to his family physician? Is he supposed to return to the attending physician or surgeon? If so, when?

There is nothing new about the discharge summary; it has been used for many years by our best hospitals, and its use is spreading. **It is not by accident that the discharge summary is customarily placed at the very front of the medical record, when the latter is filed. It is the single most useful part of the entire document.** ■



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Those Trained by O.R. Nurses Can Best Do Surgical Prepping

By Frances Ginsberg, R.N.

I SEE in the not-too-distant future a preoperative preparation procedure that will eliminate all of the current practices, both good and bad. Until that time, however, there is still no reason that this important procedure cannot be done with a maximum of asepsis and to the satisfaction of the surgeons.


Frances Ginsberg

Ideally, the preoperative shave should be done *immediately* before surgery. The possibility of bacterial reproduction through open pores and the abrasions of the skin is thus reduced to a minimum.

There are those who insist on this procedure in the interest of asepsis. However, most hospitals are unable to follow it because of scheduling problems and the size of the operating suite.

Therefore, the next best method of preoperative preparation is to use the best combination of well trained personnel, soap preparations, good razors and blades, and proper technics.

I believe that the preoperative shave should be done by those specifically trained by operating room nurses rather than by those in the general nursing service. The reason is simple: The surgical nurses are the ones who have been taught and who best understand the need for proper technic and its relation to surgery. Also, if the preparation is a bad one, it can be immediately established who needs either additional or refresher training.

All of the equipment and materials used for the procedure should be in separate packages on one tray or on a portable cart. Each package should include a small basin, a supply of gauze, sponges, applicators, a razor, and soap.

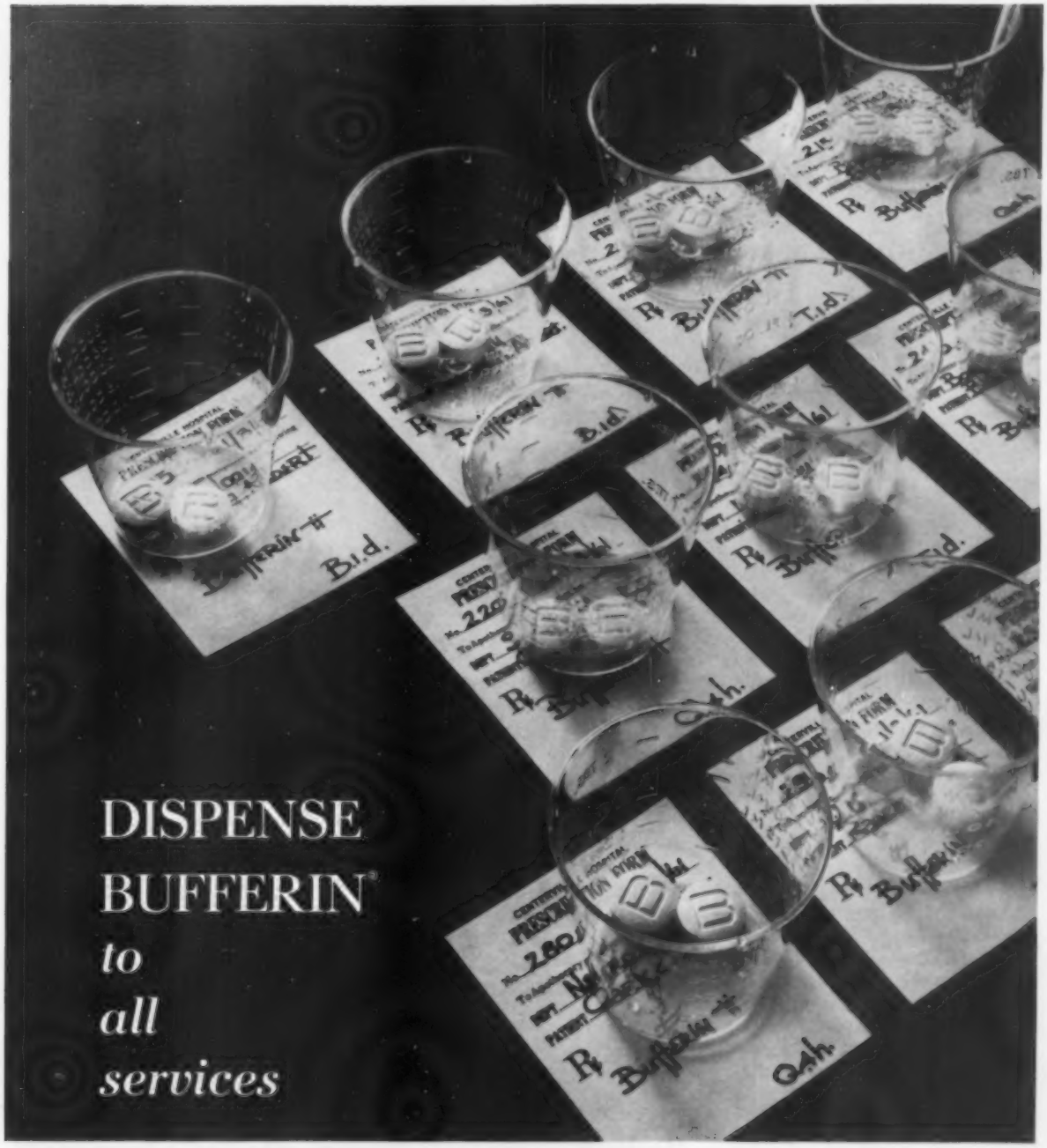
The razor should preferably be a straight razor or a stainless steel safety razor with stainless steel blades that can be autoclaved. The household variety of safety razor with carbon steel blade may be used only if the blade is discarded and the razor autoclaved after each use. Sterilization of all razors will help reduce the possibility of transmitting viral hepatitis. For this reason, the disposable one-use razor and blade has become most popular.

Soaps used for preoperative preparation should be either of the antibacterial type or the new bactericidal iodine surgical soap.

The technic should include an introduction to the patient by the person doing the preparation and an orientation to the reason for it. A bed-saver with a polyethylene liner should be placed under the area to be prepped to prevent wetting the bed linen. A towel or other linen should not be used as hair will collect and remain after laundering.

The preparation itself should consist of wetting the area with a sponge and then applying the appropriate soap worked into a heavy lather. The area then should be shaved through the lather with care taken to avoid nicking or abrading the skin. After an inspection for residual hair, the area should again be lathered and rinsed or wiped clean with dry sponges. ■

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.



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Conducted by Jane Hartman

There's Method to This Food Service Plan

Facilities, physical layout, and methods of operation all contribute to the quality of food service at Beckley Memorial Hospital, which provides round-the-clock service for patients, visitors and staff from one kitchen

Steve J. Soltis and Katherine D. Spencer

HOW hospital food services are organized determines, to a large extent, how effectively they meet the round-the-clock requirements of three special groups—inpatients, hospital staff, and outpatients and visitors.

At the 200 bed (85 per cent occupancy) Beckley Memorial Hospital, Beckley, W.Va., all food is prepared in the same kitchen by the same employes for patients, employes and guests. The nutrition and dietary service is staffed from 1:30 a.m. to 1 a.m. daily. Food is available at any time that it may be needed for a patient.

Central tray service for hospitalized patients is provided by a horizontal tray conveyor belt leading into a vertical shaft. This vertical shaft has an opening on each floor for removal of trays.

Late trays and between-meal feedings are sent to the floors on the kitchen dumb-waiter, which opens into the clean utility area on each floor. Between-meal feedings are served only as a part of a therapeutic diet or at the request of the head nurse when a patient has not been able to eat at a regular mealtime.

The kitchen is compact and arranged to save steps. It is divided into eight areas: storage (refrigerated and dry), salad preparation, vegetable preparation, hot food preparation, bakery, dishwashing, utensil washing, and office space. The produce refrigerator is located adjacent to the salad preparation area and is equipped with a double stainless steel sink and drainboard and a garbage disposal unit. Bulk storage of sack vegetables is next to the vegetable peeler and double stainless steel sink and drainboard.

The steam-jacketed kettles, vegetable steamer, and large mixer are in the area across from the vegetable preparation area, which results in a saving of time and many steps for those assigned to do this work. These are backed by the divider separating this area from the bain marie, broiler, ranges and cooks' ovens so that the cooks also have easy access to this equipment. The hot food preparation area faces the end of the tray conveyor, giving easy access to the hot food setup for serving patients' trays.

The meat refrigerator, walkin freezer, dairy refrigerator, and dry storage are adjacent to the receiving area, yet are within 40 feet of the hot food preparation area and the bakery.

The dishwashing area is also opposite the ranges and ovens. The dishes are returned to the scraping end of the vertical tray conveyor which is reversed to bring the soiled dishes down from the patient floors and the cafeteria. In addition to the dishwashing machine, there is a glasswashing machine, a soak sink, and a garbage disposal unit.

At the end of the kitchen, opposite

This pay cafeteria is for the use of staff and visitors. The food served here is prepared in same kitchen and by same personnel responsible for patient meals.

Mr. Soltis is administrator and Mrs. Spencer is director of the nutrition and dietary service, Beckley Memorial Hospital, Beckley, W. Va.

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bright new plastic doors add color to cooler and freezer rooms

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the cooks' and baker's ovens, are the triple pot-washing sink and another garbage disposal unit. The third sink is equipped with live steam and a thermometer and the pots are sanitized with 180 F. water.

The baker has her own area which includes a refrigerator, range, ovens, scales and mixers. All of the baked goods, except white and whole-wheat bread, and hamburger and frankfurter buns, are produced in the bakery area.

The assistant director of nutrition and dietary service, who is responsible for food production, and a clerk have a small glass-enclosed office, located so that most areas of the kitchen are visible. Employe conferences are conducted in the office of the director of nutrition and dietary service, located off the hallway leading to the kitchen. Desks for two staff dietitians and the food supervisors are in the kitchen.

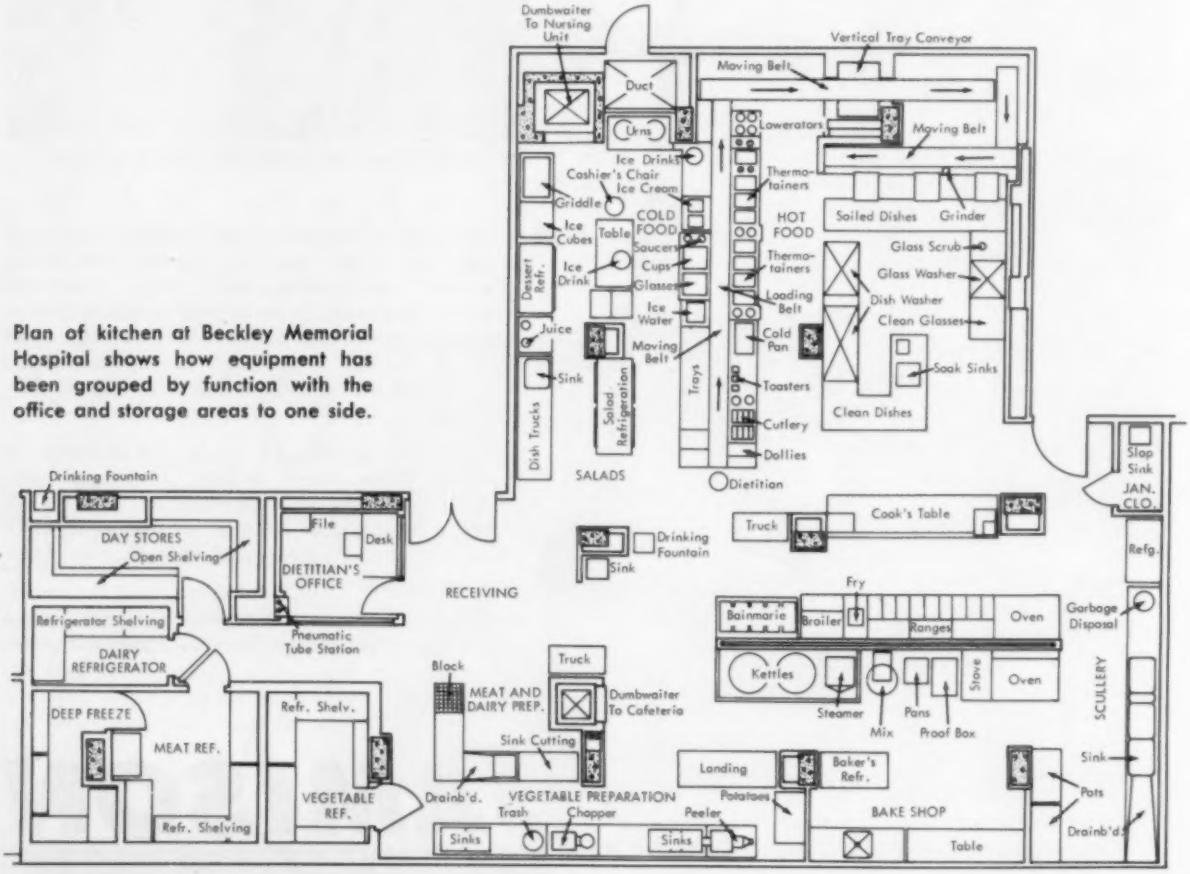
A cycle menu was put into use after a study was made of the acceptability of certain foods and the food habits of the people in this region. This menu is planned to cover a period of six weeks, then repeated once. In this way, appropriate quarterly menus can be planned. Thus the cycle menu aids in regulating food orders and in planning the annual budget for food. A perpetual inventory is kept on all food items, and it can be seen immediately how much of an item is needed in any month or quarter.

Recipes Are Standardized

Standardized recipes have been developed and are used for all items appearing on the menus. By means of these recipes, the training of cooks is simplified, the finished product is uniform, the sizes of servings are uniform, and the evaluation of food nutrients in the diet is simplified. Patient menus are checked periodically against the recommended allowances of protein, fat, carbohydrates, minerals, vitamins and calories as set up by the National Research Council. The use of standardized recipes also permits work simplification as each recipe is always prepared in the same way, and the cooks can organize their work better. As a result, steps and time are saved. These recipes are set up for 25, 50 and 100 portions for use on patient and cafeteria menus. Therapeutic diet recipes are set up for 5, 10 and 25 portions. Corrections in pricing are done every six months or when there has been a decisive change in price on any of the ingredients.

Prefabricated meat cuts are found to be an economical unit of purchase and to produce uniform servings. Some of the fish, poultry, fruits and vegetables are purchased frozen and stored in the walkin freezer. The amount of food in the walkin freezer is planned for approximately a 45 day period. Items such as stews, casserole dishes, meat pies, fruit pies, and cakes are often prepared in excess of

(*Continued on Page* 140)



Plan of kitchen at Beckley Memorial Hospital shows how equipment has been grouped by function with the office and storage areas to one side.

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Model SD-2 has three dispenser heads. Can supply up to 500 lbs. of Super Flakes daily.

OTHER SCOTSMAN SUPER FLAKERS . . . both of the self-storing and continuous-flow variety . . . fill out the capacity range between these two extremes . . . meet any in-between need for 100% pure flaked ice.

IN ADDITION, SCOTSMAN now has *two* models of its Combination Ice Machine and Drink Dispenser . . . with ice making capacities of either 350 or 550 lbs. of ice flakes per day, and mounting either two or three standard one gallon dispenser heads.

Both of these amazing models, which give you *both* ice and iced drinks from the *same* machine, are illustrated at left.

SO REMEMBER . . . if you use flaked ice *at all* in your business . . . even as little as a few pounds per hour or as much as 2¼ tons per day . . . only SCOTSMAN has all the models to fit all your needs exactly! See them today at your nearby home area Ice Machine Specialist . . . your SCOTSMAN Dealer or Distributor.

(And remember, also, that Scotsman makes a complete line of Super Cubers and Super Bins . . . ask to see them, too!)

SCOTSMAN

Modernize with Modern Ice!

ICE MACHINES

YES! Please send complete details, including new "Ideas on Ice" booklet on Scotsman Ice Machines.

NAME_____

ADDRESS_____

CITY_____ ZONE____ STATE_____

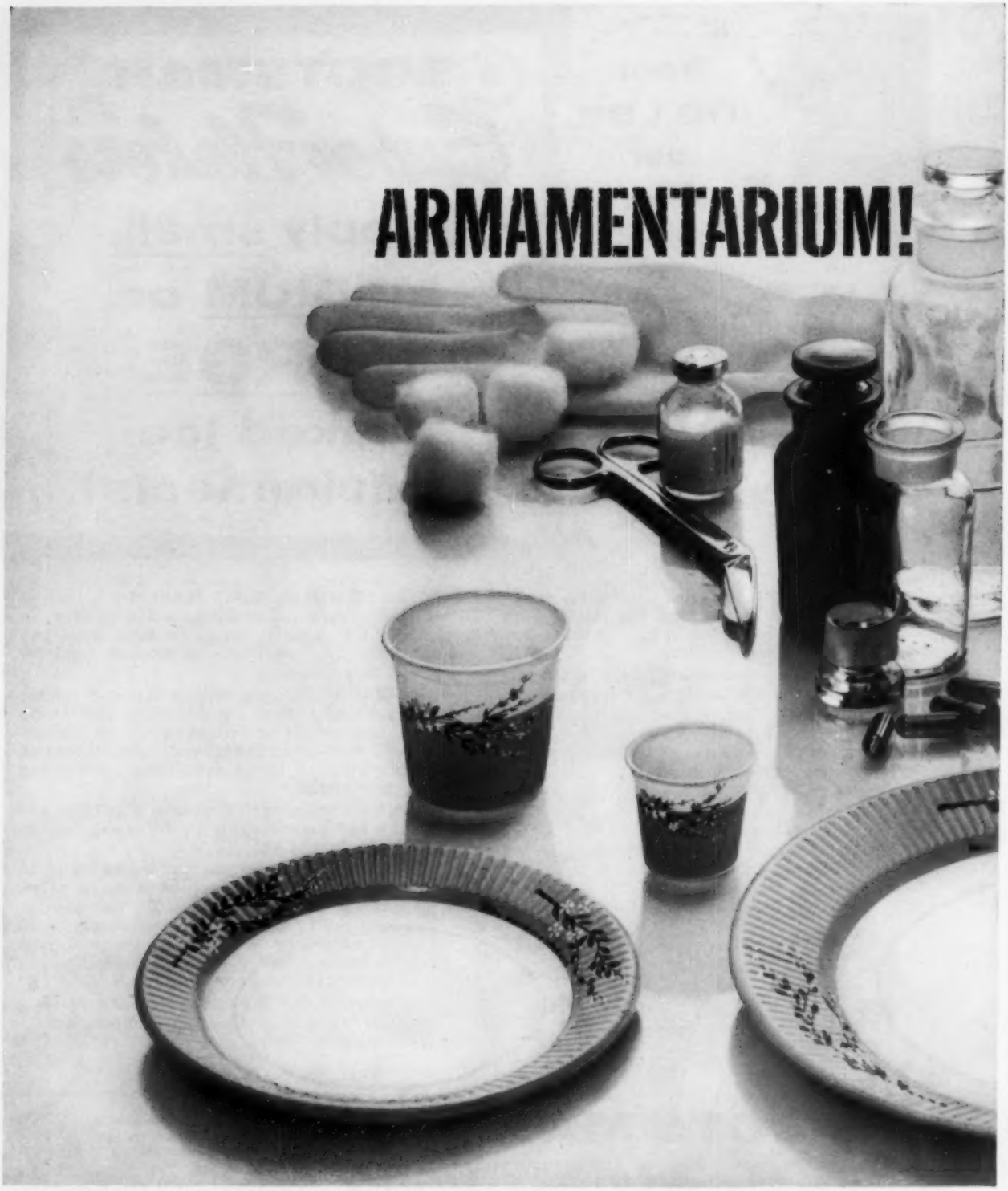
MAIL TO: **SCOTSMAN ICE MACHINES**

Scotsman Queen Products Div. of King-Seeley Thermos Company

94 Front Street, Albert Lea, Minnesota

Export Office: 15 William St., New York, N. Y.

For additional information, use postcard facing back cover.



In the guerilla war against cross-infection, Dixie Matched Food Service has an important part. It is certainly not your only weapon. But not to be overlooked. Because staph and his brothers are subtle, adaptive opponents—and Dixie Service means fewer chances for careless errors. (Examples: a kitchen worker with a cut finger...a plate not completely scraped. You know the problems.) So staph has fewer chances to spread. Other important advantages: Dixie has the most extensive matched line on the market—and the exclusive Mira-Glaze® hot-drink cup. That Dixie Mira-Glaze Cup has a unique polyethylene lining that ends cardboard taste and "plastic" odor. As for the matched service — that's 23 different pieces in one cheerful pattern...tray after tray that looks as though your hospital cares about its patients. Morale-building, and practical. Because this large a selection allows you to choose your cups and plates for precise portion control, cutting down

on waste. You also cut down on slack work periods, because this complete paper service allows you to portion in advance. You save on breakage, too. Not to mention dish washing and storage costs. One last thought: patients appreciate Dixie service. They like the way it looks. They like the way it doesn't taste. And they like the fact that it makes meal service quicker and faster. Most important, they respect Dixie Matched Food Service for what it is: a tangible safeguard against cross-infection. Your Dixie Cup representative has facts and hospital case-histories you should know about. Call or write today.

DIXIE*CUPS ARE PRODUCTS OF AMERICAN CAN COMPANY

Dixie Cup Division of American Can Company, Easton, Pa., Chicago, Ill., Darlington, S. C., Fort Smith, Ark., Anaheim, Cal., Lexington, Ky., Brampton, Ontario, Can. *"Dixie" is a registered trade mark.

(*Continued From Page* 136)

the quantity needed for a particular meal and frozen for future use. At other times, when the cooks' and baker's schedules permit, these as well as other items are prepared for the freezer. When such items as turkeys and chickens are purchased at a saving, these are prepared for the freezer, which is kept at subzero temperature. The turkeys are boned, rolled and tied, and the chickens are cut into portions.

The patients' tray service, mentioned previously, deserves more detailed attention because the planning and coordination involved contribute conspicuously to better patient care. As indicated, the patients' tray service is centered around a horizontal moving tray conveyor in the kitchen and a vertical tray conveyor to the floors. Patients receive a selective menu on the noon tray for three meals beginning with the noon meal the next day.

Nursing service collects and sends to the kitchen the patients' marked food selections. The evening cashier in the cafeteria tallies the food items and posts them in the kitchen for use the next day. The dietitians write the therapeutic and children's diets, using the selective menu as a basis.

The menus are arranged in sequence, beginning with the highest numbered room and progressing to the lowest. This system prevents cross-traffic on the floors when the trays are carried, assists nursing service in checking to see that all patients have been served, and assures service to a complete ward regardless of the patients' prescribed diet variations. In this way, no patient feels left out, and all can eat at the same time.

Trays are set with the tray cover, napkin, silverware, saucer, salt, pepper and sugar. Set trays are stacked alternately on movable carts which are placed adjacent to the head of the tray conveyor. Some of these items may be added or removed when the menu is placed on the tray before placing it on the tray conveyor belt.

Hot foods are located on one side of the belt in hot food receptacles, and heated units contain the appropriate dishes. The other side of the belt is set up with cold foods. Refrigerators for salads and desserts are directly behind the person serving these on the tray line. Hot beverages are served from the cold side as the urns are located on that side so that the hot beverages are placed on the tray just prior to the checking point.

Insofar as possible, the person who prepares the food serves it. For example, a cook serves the meat and potatoes, the nourishment girl serves cold beverages, and so forth. When a person who has prepared an item for the patients' trays also has to serve it, he takes more pride in his work, serves the item so that it looks better on the tray, and is careful to serve the standardized portion, we have found. Eight people are required for the serving of each meal — four serving hot foods, three serving cold foods, and one starting the trays at the head of the tray conveyor.

Menus are marked for therapeutic diets with different colored pencils to indicate the type of diet—red for diabetic and low-caloric diets, blue for bland diets, green for low-fat diets. This alerts the employes serving food and eliminates their having to read the name of the diet. The employes are briefed before the meal is to be served concerning the menu

(*Continued on Page* 143)

THIS FOOD STAYS FRESH LONGER IN A VICTORY V-LINE

people of distinction specify, sell and use this distinctive line

The controlled humidity ever-present in V-line® refrigerators combats drying-out of costly foods and cuts down wasteful shrinkage, which can actually mean "money in the bank" for you.

Experience has proven that V-line® refrigerators cost less to operate and have greater uniformity of temperature throughout. This is why V-line® is the first choice of seasoned buyers.

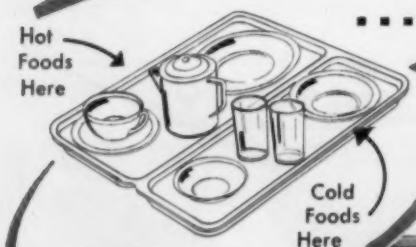
Sold only through exclusive franchise distributors. Factory representatives in all principal cities.

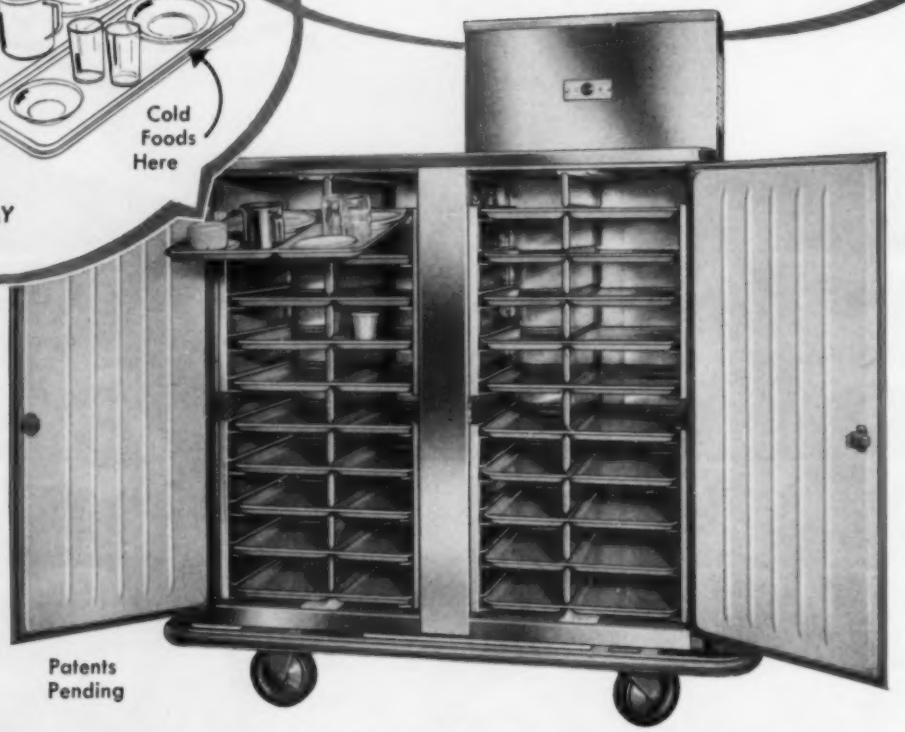
Write today for literature.

VICTORY
METAL MANUFACTURING CORPORATION
PLYMOUTH MEETING, PA.

New Ideal UNITRAY

Hot foods Hot . . Cold foods Cold
. . . ALL ON THE SAME TRAY





The Unitray Concept — the newest, most modern method for centralized food service in hospitals was developed in conjunction with Mr. Henry Rothman, F.F.E.S., one of the nation's leading food service consultants.

Now, for the first time, you can have *all* of the advantages offered by "All on the same tray" service. No longer do you have to worry about the proper combining of hot foods onto the cold tray at a point distant from the kitchen.

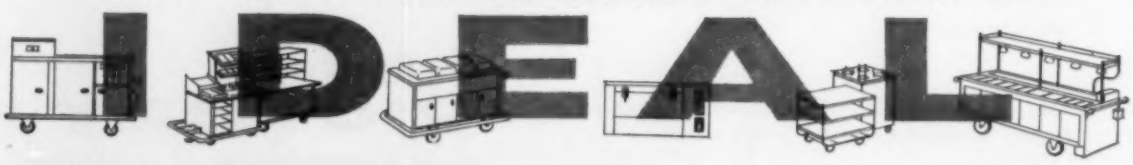
IDEAL'S "All on the same tray" Unitray cart makes complete kitchen control of the centralized food service system possible.

A unique new method permits one side of the tray to be exposed to refrigeration while the other-side of the tray is exposed to heat. Thus, hot foods stay hot and cold foods stay cold — all the time.

Now, the tray can be completely assembled in the main kitchen. The complete tray set up is checked by the Dietitian just before the tray is put into its proper place in the cart. No reshuffling of tray items before delivery to patient. One set up — one check, and the tray is ready for delivery to the patient. Excellent holdover qualities built into the cart make it possible to maintain both hot and cold temperatures, even over long periods of time. Twenty trays in less space than ever before! The new Unitray carries 20 trays with plenty of room for a 10 ounce glass to stand upright on the tray. Yet, the overall length of the cart is only 53¾" almost ⅓ less than old fashioned carts.

Write today for live demonstration of Unitray in your hospital

SWARTZBAUGH MANUFACTURING CO., Murfreesboro, Tenn.



INSTITUTIONAL EQUIPMENT • for modern institutions everywhere

(*Continued From Page* 140)
and any particular points in the serving of the food.

The food supervisor checks the trays for accuracy, appearance and completeness before they enter the vertical shaft. The trays enter the vertical shaft at an average of seven per minute or approximately one every eight seconds. The vertical tray conveyor automatically stops if for any reason a tray is not removed. The tray conveyor can also be stopped by the person removing the trays on the floors or by the food supervisor in the kitchen.

Prior to taking the trays to the patients, who are served at the same time each day, a member of the nursing team gets the patient ready for his meal, and the persons who are going to carry the trays adjust their hair nets and wash their hands.

An employe from the nutrition and dietary service is assigned to remove the trays from the tray conveyor in the clean utility area on the patient floors. The trays are placed on a counter and are ready to be carried to the patient. Each tray is carried individually to the patient by housekeeping maids, nursing aides, and licensed practical nurses, or registered nurses in an emergency. The person carrying the tray identifies the patient to assure that the patient receives the correct tray.

Soiled trays are collected on a large cart by housekeeping personnel and are returned to the soiled utility area. An employe from the dietary service is assigned to send the soiled trays back to the dishwashing area. This is accomplished by reversing the vertical tray conveyor so that trays move downward and out of the shaft to the dish-scraping area where kitchen helpers are waiting to dismantle them for the dish machine operators.

As a part of the Miners Memorial Hospital Association chain, Beckley Memorial benefits from large-scale central purchasing, standardization of basic equipment, inventory and accounting methods, and association-wide personnel methods. Within this framework, each hospital administrator and dietary service director has full opportunity for experimentation and variations to meet local needs. ■

(Next month the authors will discuss how the personnel aspect of food service has been organized at Beckley Memorial Hospital.)

Training Helps Food Service Employes See How Diet Is Related to Disease

Basic lessons in nutrition and the reasons for special diets for different diseases gave food service employes more pride in their work

Margaret E. Graham

THE relationship between diet and disease must be understood by the professional employes of the dietary department — and the responsibility for accomplishing this rests with the dietitian. At Fort Howard Division V.A. Hospital, Baltimore, we have found a way to help these employes take more pride in their work by making clear the role of food service in total patient care.

A series of nine classes conducted here proved successful in teaching dietary personnel the basic principles of dietetics and creating greater interest in their work.

Our first step in teaching the elements of nutrition was a brief discussion of the source and function of carbohydrates, proteins, fats, vitamins, minerals and water.

It was important to teach employes not only about foods but also the reasons for various forms of diets. The employe can understand why liquid diets are given to patients who have had their teeth pulled recently or who have had their teeth wired together because of a fractured jaw; but many of them do not understand why a patient is on a liquid diet when he has red marks on his face.

We explained that red marks denote the area of the body where the patient is receiving x-ray therapy, often for some type of cancer tissue. Patients receiving this type of therapy become nauseated and do not feel like eating. Realizing this, and with the knowledge they had that proteins are important in rebuilding destroyed tissue, our employes began encouraging these patients to select such things as custards and eggnogs in their diets. The value of this program was apparent when some of these patients thanked the employes for helping them to select these foods.

Then we began teaching the effects of various diets on diseases or malfunctioning organs. For example, we explained that ulcers may be the result of alcoholism, chemotherapy and so forth. To demonstrate how various ulcers may be affected by some diets, we placed a piece of raw beef in alcohol, a carbonated soft drink, hydrochloric acid (the same concentration that is in the stomach), and milk. We then discussed various ulcer regimens, stressing the importance of a bland diet.

To explain why a patient may have pain when he eats a diet with roughage or cellulose in it, we made a drawing of the intestine showing the villi and how, once the villi are irritated, foods with high cellulose content will irritate the intestinal tract. Several intestinal surgical procedures were also discussed at this time.

One class considered the role the liver plays in the body and the part that food plays in healing the liver when it becomes diseased. We found that we did not have to go into detailed medical terms to explain the liver if we showed the employes a picture of a cross-section of the liver. The question was raised why patients with liver malfunctions have to be on a sodium restricted diet. To answer, we said that these patients are collecting water in the body tissues. With sodium restriction, water is not kept in the tissues, but excreted. A picture was used to show where the gall bladder is in relation to the liver and the intestinal tract, and what its role is. The importance of restricted fat intake in the body was discussed.

The next sessions dealt with diabetes mellitus because the liver plays an important role in that disease. The importance of serving the correct amount of food was stressed because of the correlation between diabetes mellitus and overweight. We showed the employes examples of neuropathies and ulcers of the legs and feet of diabetics with uncontrolled diets. It was pointed out that some patients are on diabetic diets for only a short time and then returned to a regular diet because some medicines elevate the blood sugar level and a diabetic diet is prescribed.

The concluding class was on the heart and kidneys. To illustrate the role sodium plays in keeping water in the body tissue, a small balloon containing some water was placed in a container of salt water, and the personnel watched the salt solution burst the balloon.

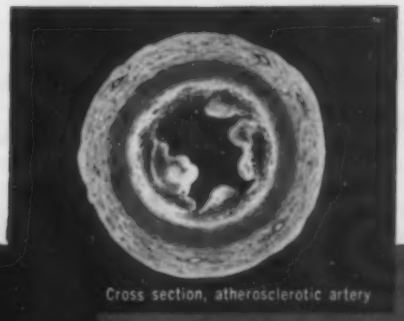
We discussed the low protein diet for those patients with kidney malfunctions and pointed out to the employes how diets may conflict if a patient has a heart as well as a kidney malfunction.

In teaching the food service personnel, I found an analogy to the various parts of an automobile was effective in illustrating the importance of the diet to the various physiological malfunctions. A statement that is well remembered is that parts of an automobile can be replaced, but parts of the human body cannot.

It must be made clear to food service personnel that only through proper medical and dietary care can the patient regain his health. ■

Miss Graham is clinic education dietitian, Fort Howard Division, V.A. Hospital, Baltimore.

outstanding nutritional research achievement



Cross section, atherosclerotic artery

to aid in the dietary control of serum cholesterol

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scientifically formulated with pure liquid **non-hydrogenated** MAZOLA Corn Oil.

MAZOLA Margarine is an economical tablespread and serves as a solid shortening, rich in linoleates and low in saturates—making it an ideal dietary adjunct in the management of serum cholesterol. It contains 2 to 3 times as much natural linoleic acid as any other margarine readily available in grocery stores from coast to coast, and 5 to 8 times as much as butter. It contains no dairy or animal fats, no coconut oil, and no cholesterol.

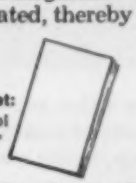
MAZOLA Margarine is indistinguishable from other quality margarines as to taste, aroma and handling characteristics. Thus, it can be part of the regular diet for the whole family, including the hypercholesterolemic patient. The major ingredient in MAZOLA Margarine—liquid MAZOLA Corn Oil—is NOT hydrogenated, thereby preserving its rich content of linoleates.

The average daily intake, two ounces or 56.8 Gm. (4 tablespoons) of MAZOLA Margarine, supplies

Linoleic acid	12 Gm.
Oleic acid	23 Gm.
Saturated fatty acids	8 Gm.
Plant sterols (sitosterols)	215 mg.
Natural tocopherols	30 mg.
Vitamin A	1870 USP units
Vitamin D	290 USP units
Calories	415

Available in the refrigerator sections of grocery stores in the same general price range as other premium quality margarines, in 1-lb. packages (four ¼ lb. sticks).

Send for free booklet:
"Recent Advances in the Dietary Control of Hypercholesterolemia."



BEST FOODS • Division of Corn Products Co., NEW YORK 22, N. Y.

Ice Cream Is Economical Dessert — Especially If You Make It Yourself

Jane Hartman

MANY hospitals and similar institutions throughout the country make their own ice cream, sherbets and fresh fruit ices in order to reduce the cost of these desserts. One food service director has been quoted as saying: "Ice cream is the least expensive dessert we serve, and is the most acceptable."

Jane Hartman

One way for the hospital to make its own frozen desserts is to purchase ice cream mix from a local dairy. Ice cream mix is made in standard formulas. The determining factor is the amount of butter fat; the most widely used formula is 12 per cent. The cost of a gallon of this product will vary depending upon the section of the country. A fair average price is $1.40 per gallon. In making ice cream, however, "overrun" is obtained. During the freezing process a certain amount of air is incorporated that enables the operator to draw from the ice cream freezer two gallons for every gallon of mix placed therein. This reduces the cost per gallon to approximately 70 cents, to which, of course, is added the cost of flavoring. When extracts such as vanilla or coffee are used, the flavoring cost is quite reasonable (approximately 3 cents per finished gallon). Fruit flavors cost more and often range between 10 and 20 cents per gallon.

Sherbets, using the finest ingredients, cost between 50 and 55 cents per gallon, and fresh fruit ices cost 25 to 30 cents per gallon.

It is easy to see that making ice cream is much less expensive than purchasing it. Ice cream costs from $1.50 to $2.25 per gallon. **The important factor in determining whether your hospital should make ice cream or not is the amount used.** One equipment manufacturer uses the number of beds in the hospital as the determining factor, believing that it pays to make ice cream in an institution of 200 beds or more. Another method is determining the amount of ice cream used per year using the figure of 2500 gallons per year (based on serving ice cream twice a week) as the point where ice cream making equipment becomes economical.

When a packaged control system with an ice cream filling machine is used, it is possible to serve 32 four-ounce servings from every gallon of ice cream frozen. Incidentally, a four-ounce serving is generally one-third larger than the normal cup used commercially. **Including the cost of the cup, flavoring and ice cream mix, a serving of ice cream should cost no more than 3 cents.** Sherbets run approximately 2 cents and fresh fruit ices 1 cent. This is based on using the standard souffle cups used for desserts in institutions.

Ice cream making is extremely simple; equipment manufacturers as well as suppliers of the various ingredients are pleased to instruct hospital personnel in the operation of the equipment. They naturally are anxious to see that their products are shown to the best advantage.

In some instances, ice cream making equipment has enabled hospitals to serve ice cream often when previously they served it only on holidays and special occasions.

Labor hour studies indicate low labor cost per serving. Considering variations in labor cost per hour in various sections of the United States, the average cost per serving varied from $0.00125 to $0.0025. Most hospitals use food service workers rather than cooks for ice cream making. ■

The hospital that makes its own ice cream can find many ways to use it for a variety of economical desserts. These parfaits, for example, combine it with gelatins, puddings, cookie crumbs, fresh and frozen fruit, and whipped cream.

Menus for May 1961

Marion Peterson
Chief Dietitian
Norwood Hospital
Norwood, Mass.

1
Orange Juice
Poached Egg on Toast
•
Julienne Vegetable Soup
Cheeseburger
Buttered Peas
Blushing Pear Salad
Tapioca Cream Pudding
•
Cream of Potato Soup
Breaded Veal Cutlet, Cream Gravy
Parsley Buttered Potatoes
Buttered Cauliflower With Bread Crumbs
Tossed Salad
Gelatine Cubes

2
Baked Apple
Soft Cooked Egg, Muffin
•
Tomato Bouillon
Asparagus au Gratin
Julienne Carrots
Lettuce Wedge, 1000 Island Dressing
Fresh Fruit Cup
•
Chilled Cranberry Juice
Roast Leg of Lamb, Brown Gravy, Mint Jelly
Franconia Potatoes
Buttered Wax Beans
Gingerale Salad
Ice Cream and Cookie

3
Pineapple Juice
Scrambled Eggs, Bacon
•
Scotch Broth
Chicken Salad Roll, Potato Chips, Tomato Wedge
Buttered Spinach
Molded Cranberry-Apple Salad
Lady Baltimore Cake
•
Cream of Celery Soup
Liver Bernaise
Baked Potato
Mixed Vegetables
Confetti Coleslaw
Strawberry-Banana Cup

4
Stewed Prunes
Soft Cooked Egg
•
Cream of Mushroom Soup
Hot Meat Sandwich
Julienne Green Beans
Sliced Tomato, Celery With French Dressing
Fruit Gelatin With Whipped Cream
•
Chicken Noodle Soup
Swiss Steak
Whipped Potatoes
Harvard Beets
Peach and Cottage Cheese Salad
Ice Cream and Cookie

5
Poached Egg on Toast
Cranberry-Orange Muffin
•
Clam Chowder
Tunafish Salad Plate With Potato Sticks and Relishes
Stewed Tomatoes
Orange and Grapefruit Salad
Frozen Cherry Cobbler
•
Chilled Pineapple Juice
Baked Halibut Steak au Gratin Potatoes
Buttered Lima Beans
Chef's Salad
Prune Whip

6
Sliced Bananas
Scrambled Eggs, Bacon
•
Minestrone Soup
Cold Cuts and Potato Salad
Buttered Brussels Sprouts
Waldorf Salad
Chocolate Pudding With Whipped Cream
•
Cream of Corn Soup
Yankee Pot Roast
Browned Potatoes
Buttered Asparagus
Carrot and Raisin Salad
Marble Cake With Mocha Frosting

7
Sectioned Grapefruit
Soft Cooked Egg
•
Cranberry Foam Cocktail
Broiled Sirloin Steak
Mashed Potatoes
Broccoli Hollandaise
Head Lettuce, Roquefort Dressing
Chocolate Sundae
•
Consomme With Noodles
Creamed Chipped Beef on Toast
Buttered Hubbard Squash
Pineapple Slice and Grated Cheese Salad
Raspberry Squares

8
Tomato Juice
Scrambled Eggs, Bacon
•
Mulligatawny Soup
Beef Pie
Buttered Cream Style Corn
Blackberry Gelatin Fruit Salad, Mayonnaise
Pineapple Upside-Down Cake
•
Chilled Vegetable Juice
Fried Chicken
Baked Potato
Mixed Vegetables
Celery Hearts and Olives
Date and Nut Pudding

9
Stewed Fresh Rhubarb
Soft Cooked Egg
•
Chicken Gumbo Soup
Braised Short Ribs of Beef
Buttered Cut Green Beans
Tomato, Sliced Egg Salad, French Dressing
Floating Island
•
Cream of Pea Soup
Roast Leg of Veal, Gravy
Browned Potatoes
Buttered Shoestring Beets
Perfection Salad, Mayonnaise
Ice Cream and Cookie

10
Apple Juice
Poached Egg, Bacon
•
Tomato Bisque
Meat Loaf
Buttered Peas
Sunset Salad
Cream Puff
•
Chilled Grapefruit Juice
Baked Ham With Raisin Sauce
Delmonico Potatoes
Spinach With Egg
Grapefruit-Avocado Salad, French Dressing
Strawberry Bavarian Cream

11
Cantaloupe Wedges
Soft Cooked Egg, Biscuits
•
Vegetable Beef Soup
Club Sandwich, Potato Chips
Buttered Carrot Coins
Pear in Lime Gelatin
Devil's Food Cake
•
Cream of Spinach Soup
Lamb Chops, Mint Jelly
Whipped Potatoes
Stewed Tomatoes
Fresh Fruit Salad With Creamy Mayonnaise
Ice Cream and Cookie

12
Fresh Applesauce
Scrambled Eggs
•
Fish Chowder
Seafood Newburg on Toast
Buttered Green Beans
Tomato Aspic Salad
Lemon Meringue Pie
•
Chilled Pear Nectar
Baked Stuffed Fillet of Sole
Tartare Sauce
Parsley Buttered Potatoes
Mashed Butternut Squash
Mixed Vegetable Salad
Fruit Gelatin

13
Prune Juice
Soft Cooked Egg
•
Chicken Bouillon
Braised Sirloin Tips
Buttered Succotash
Tomato-Asparagus Salad, French Dressing
Chocolate Brownies
•
Chilled Grape Juice
Broiled Ham Slice With Pineapple Sauce
Buttered Diced Potatoes
Buttered Wax Beans
Raisin Sunshine Salad
Lemon Delicacy

14
Sectioned Orange
Poached Egg on Toast
•
Grape Juice Punch
Roast Capon, Cranberry Sauce
Whipped Potatoes
Buttered Brussels Sprouts
Mixed Green Salad, French Dressing
Ice Cream With Strawberry Sauce
•
Tomato Rice Soup
Waffles and Crisp Bacon
Frosted Peas
Orange and Date Salad
Spice Cake

15
Blended Juice
Scrambled Eggs, Bacon
•
Cream of Asparagus Soup
Swedish Meat Balls
Buttered Tiny Whole Beets
Stuffed Celery, Carrot Curls
Spanish Cream
•
Chilled Tomato Juice
Veal Birds With Cream Gravy
Baked Potato
Buttered Broccoli
Molded Cranberry Salad
Chocolate Eclairs

16
Kadota Figs
Soft Cooked Egg
•
English Beef Broth
Grilled Ham, Scalloped Potatoes
Buttered Lima Beans
Confetti Coleslaw
Coffee Souffle
•
Cream of Mushroom Soup
Pot Roast of Beef With Vegetable Gravy
Franconia Potatoes
Buttered Asparagus
Plum Cartwheel Salad
Harlequin Ice Cream

17
Pear Nectar
Scrambled Eggs, Bacon
•
Cream of Chicken Soup
Toasted Bacon, Lettuce and Tomato Sandwich
Chopped Spinach
Cottage Cheese Salad
Charlotte Russe
•
Minestrone Soup
Chicken a la Maryland
Mashed Potatoes
Buttered Carrots
Melon, Grape, and Bing Cherry Salad
Butterscotch Pudding

18
Grapefruit Juice
Poached Egg on Toast
•
Beef Consomme
Italian Spaghetti With Meat Sauce, Cheese
Mixed Vegetables
Molded Waldorf Salad
Prune Whip and Custard Sauce
•
Chilled Orange Juice
Roast Leg of Lamb, Brown Gravy, Mint Jelly
Browned Potato
Zucchini Squash
Chef's Salad
Chocolate Chip Ice Cream

19
Soft Cooked Egg
Toasted English Muffin
•
Oyster Stew
Lobster Salad Roll
Potato Chips, Tomato
Buttered French Style Green Beans
Jellied Pineapple and Pear Salad
Sponge Cake
•
Chilled Pineapple Juice
Broiled Swordfish Steak
Creamed Diced Potatoes
Scalloped Tomatoes
Old-Fashioned Coleslaw
Snow Pudding

20
Sliced Bananas
Soft Cooked Egg
•
Scotch Broth
Hungarian Goulash
Cauliflower Hollandaise
Fruit Medley Salad
Gingerbread With Whipped Cream
•
Cream of Tomato Soup
Smothered Steak
Whipped Potatoes
Buttered Julienne Carrots
Sliced Eggs and Asparagus Spear Salad, French Dressing
Blueberry Shortcake

21
Pineapple Juice
Poached Egg on Toast
•
Chilled Vegetable Juice
Roast Ribs of Beef au jus
Browned Potato
Buttered Spinach
Celery Hearts and Stuffed Olives
Ice Cream, Peach Sauce
•
Julienne Vegetable Soup
Baked Macaroni and Cheese
Buttered Sliced Beets
Jellied Pineapple and Pear Salad, Mayonnaise
Boston Cream Pie

22
Scrambled Eggs, Bacon
Apple Muffin
•
Chicken Gumbo Soup
Hamburg Pinwheels
Cream Style Corn
Vegetable Salad, Russian Dressing
Bing Cherries
•
Grapefruit Juice
Roast Leg of Veal, Gravy
Mashed Potatoes
Broccoli Hollandaise
Lettuce Hearts, 1000 Island Dressing
Butterscotch Brownies

23
Orange Juice
Soft Cooked Egg
•
Cream of Celery Soup
Grilled Cheese Sandwich
Buttered Peas
Jellied Fruit Salad
Vanilla Pudding With Toasted Almonds
•
Beef Consomme
Corned Beef, Mustard Sauce
Duchess Potatoes
Buttered Wax Beans
Tomato Aspic Salad
Chocolate Chip Cupcake

24
Grapefruit Half
Poached Egg, Bacon
•
Mulligatawny Soup
Shepherd's Pie
Buttered Mixed Vegetables
Orange, Banana and Grape Salad
Indian Pudding With Light Cream
•
Cream of Potato Soup
Beef a la Mode
Browned Potatoes
Buttered Brussels Sprouts
Carrot-Raisin Salad
Cheese Cake

25
Baked Apple
Scrambled Eggs, Bacon
•
Oxtail Soup
Chicken a la King
Buttered Green Beans
Blushing Pear Salad
Jelly Roll
•
Cream of Asparagus Soup
Broiled Lamb Chop
Baked Potato
Buttered Succotash
Chef's Salad, French Dressing
Brown Betty, Hard Sauce

26
Apricot Nectar
Soft Cooked Egg
•
Corn Chowder
Shrimp Wiggle on Hot Biscuits
Broiled Tomato Slice
Fresh Fruit Salad
Rainbow Gelatin Squares With Whipped Cream
•
Chilled Cranberry Juice
Baked Haddock Fillet, Tartare Sauce
Scalloped Potatoes
Corn Pudding
Fruited Cottage Cheese
Marble Cake

27
Fresh Applesauce
Poached Egg on Toast
•
Chicken Rice Soup
Beef Stroganoff
Butternut Squash With Butter
Tossed Salad
Bartlett Pear Half
•
Cream of Spinach Soup
Broiled Liver and Bacon
Buttered Diced Potatoes
Shoestring Beets
Orange and Grapefruit Salad
Norwegian Prune Pudding, Light Cream

28
Stewed Prunes
Soft Cooked Egg
•
Grape Juice
Roast Young Turkey, Oyster Dressing, Giblet Gravy
Whipped Potatoes
Buttered Peas and Carrots
Sliced Tomato Salad
Butterscotch Sundae
•
Minestrone Soup
Oven-Broiled Veal Patty
Buttered Asparagus
Gingerale Salad
Date Nut Bars

29
Apple Juice
Soft Cooked Egg, Bacon
•
Turkey Gumbo Soup
American Chop Suey
Buttered Cauliflower
Stuffed Prune and Orange Salad
Hermits
•
Chilled Pear Nectar
Baked Ham, Raisin Sauce
Parsley Buttered Potatoes
Buttered Mixed Vegetables
Waldorf Salad
Strawberry Whip

30
Sectioned Orange
Poached Egg on Toast
•
Tomato Bouillon
Standing Rib Roast of Beef
Buttered Lima Beans
Fiesta Gelatin-Sliced Peach Salad, Cream Dressing
Baked Custard
•
Beef Noodle Soup
Baked Chicken Legs
Mashed Potatoes
Buttered Broccoli
Sunset Salad, Mayonnaise
Lazy Daisy Cake

31
Blended Juice, Scrambled Eggs, Bacon • Tomato Bisque, Cheeseburger, Buttered Brussels Sprouts, Jellied Grape and Apricot Salad, Graham Cracker Pudding • Cream of Pea Soup, Breaded Veal Cutlet With Tomato Sauce, Baked Potatoes, Buttered Cut Green Beans, Confetti Coleslaw, Strawberry Shortcake.

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They Increased Laundry Output, But Not Costs

By eliminating some kinds of linen and revising work flow and distribution method, Reading Hospital is now able to process 16 per cent more laundry per employe hour at the same cost per pound

James B. Gronseth

FACED with rising costs of laundry operation and increased patient days, Reading Hospital, Reading, Pa., found a way to process 16 per cent more laundry at the same cost per pound.

Coordination of departments, in the form of a linen committee, enabled us to see our laundry and linen distribution problems more clearly and raise our output per employe hour, while keeping costs per pound the same. This was achieved in spite of increased labor costs resulting from a scheduled increment plan and two across-the-board wage increases.

Committee Studied Problem

To study our laundry problems, a committee was formed of the laundry manager, sewing room supervisor, assistant director of nursing, purchasing agent, coordinator of women's auxiliaries, and the associate administrator.

Their study disclosed need for work simplification, revision of the work flow, use of new methods, and study of linen items then in use. **Here are some of the changes made as a result of the committee's investigation:**

When the study began, the hospital was using 72 items per patient, not including special items needed by subdepartments, such as the operating room, delivery room, and central supply.

Mr. Gronseth is associate administrator of Reading Hospital, Reading, Pa.

The committee studied each item, evaluated its use, and was able to eliminate 33 items, leaving only 39 items per patient. This change did not handicap the nurses and made it possible for laundry personnel to process more linen per employe hour. **Here are some of the items eliminated or changed:**

Bassinet sheets were formerly twice as large as necessary and the nurses had been folding them in half. The sheets also had to be folded once before being put through the small piece folder in the laundry. The committee, therefore, had all bassinet sheets in stock cut in half and hemmed, thereby doubling the number of sheets available, and cutting the cost of future replacements by 50 per cent.

Baby bed blankets and baby bath blankets were both being used in the nurseries. Investigation revealed little difference in the texture or weight of the two blankets. Now one blanket is used, and storage space is saved.

Special wheel-chair blankets were eliminated and now bed blankets are used for this purpose when necessary.

Huck face towels, which require ironing, were replaced with terry cloth towels that are more satisfactory for the patient and need less handling in the laundry since they can be rough dried.

Rags were formerly of two types of material, one called "duster," the other "drier." They were passed through flatwork ironers and stacked on shelves in two areas. We now have only one type of rag, vat-dyed pink, and fluff dried in tumblers. The color enables supervisory personnel to spot use of other items for cleaning purposes.

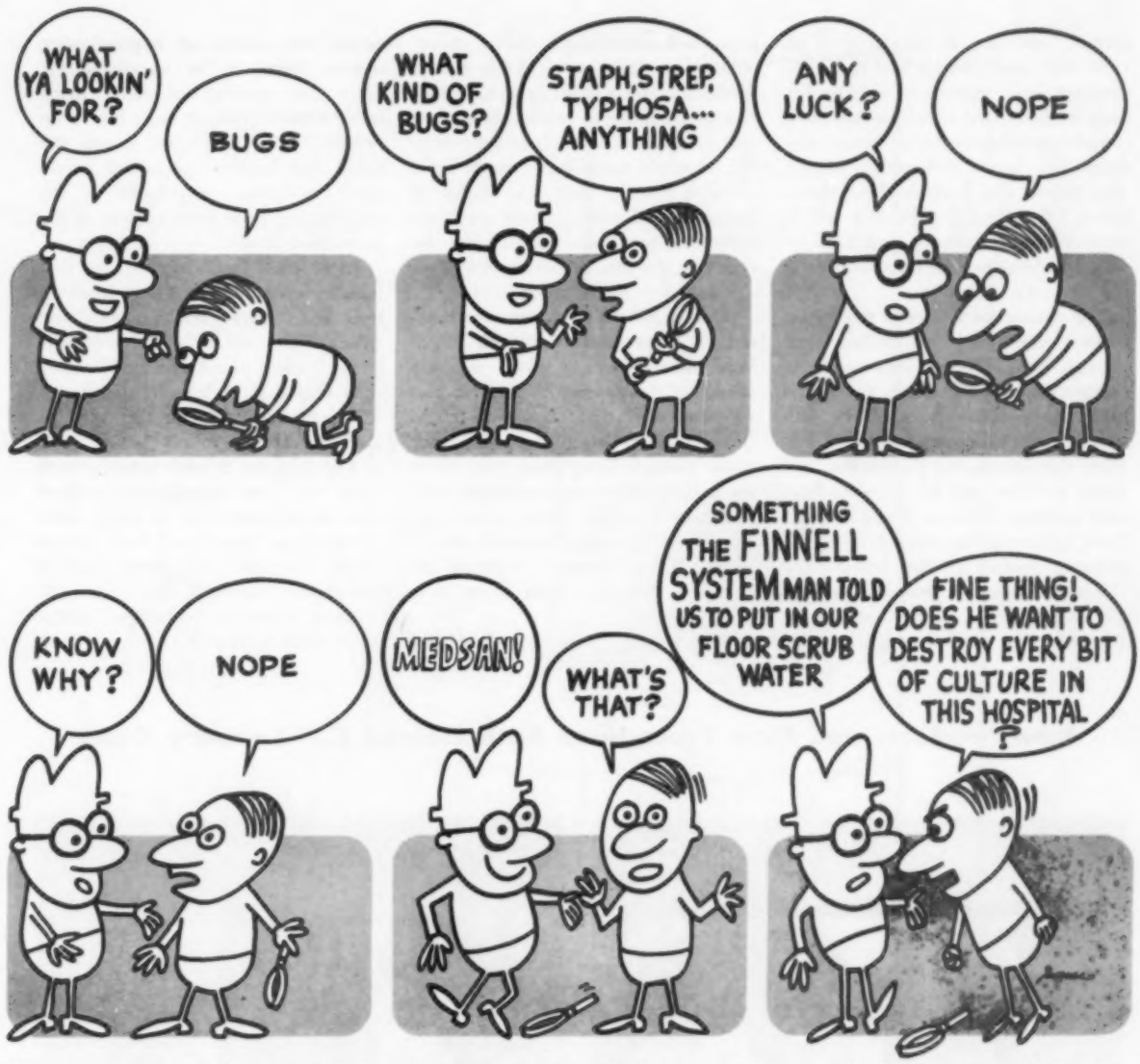
Sheets and spreads for junior beds in the children's ward, and smaller pillowcases for a child's pillow were made by hospital seamstresses. These practices were discontinued as the committee felt it would be more economical to use regular sheets, spreads, pillows and pillowcases for children, thereby eliminating additional specialty items.

Sorting Simplified

Scrub dresses in five sizes were being stamped with the name of specialty departments, making it necessary for laundry personnel to sort them into 25 separate stacks. This work was simplified after the committee recommended that scrub dresses be issued according to size only.

Items called "sterilizer" cover and "treatment" cover were found to be almost identical in size. The hospital now uses one cover for both purposes.

Preclinical student nurse uniforms have been changed to take advantage of drip-dry materials. Formerly, student nurses wore white blouses and gray skirts. Four sets were laundered each week. We have 145 be-



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ginning students, so that a total of 1160 skirts and blouses had to be assembled and identified weekly for each student. This operation has been completely eliminated, as these students now wear a drip-dry jumper with blouse and launder these themselves. This change not only saved expense in the laundry, but also resulted in less expense for uniforms in the student's tuition.

The committee observed that maintenance employes rolled up their shirt sleeves, so a decision was made to shorten all uniform sleeves and in the future to purchase new shirts with short sleeves at a reduced cost. Cuffs were also eliminated on trousers, and patch pockets will be requested for new uniform trousers. These changes have lightened the work load in the pressing section of the laundry.

Linen distribution was also revised. For many years the laundry had been preparing for each occupied bed a linen pack containing a spread, sheet, pillowcase, face towel, bath towel, washcloth, draw sheet, and a patient gown. A supply of reserve linen was also maintained in each unit by having the night nurse list items on hand on a requisition that was delivered daily to the laundry. Linen was then supplied to that department by checking the amount on hand against a quota for the nursing unit.

This distribution system was studied by the committee, which felt it was unnecessary to place a draw sheet on every patient's bed. It also recommended that the gown could be eliminated from the pack, since many patients bring their own. These recommendations were accepted with the provision that both gowns and draw sheets be supplied with reserve linen. These changes reduced the usage of these two items from 30 to 35 per cent.

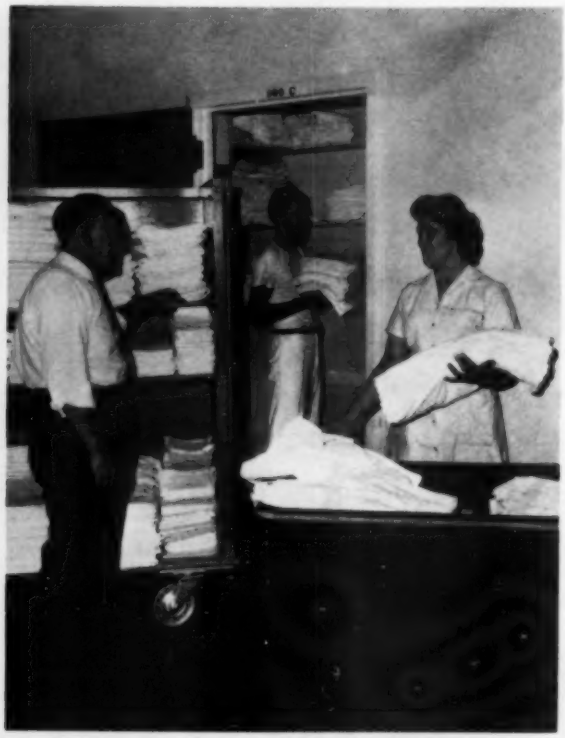
Miscounting and hoarding had caused the system of requisitioning reserve linen to be unsatisfactory. Since the number of linen items being used in patient units had been reduced from 72 to 39, it was decided that laundry personnel would take complete responsibility for maintaining floor linen closets at the prescribed levels.

Each shelf was marked so that laundry personnel, using specially built linen trucks, could quickly add items to the correct levels or remove items stacked above the marks. More than four tons of linen is distributed to the patient units in this way six days a week.

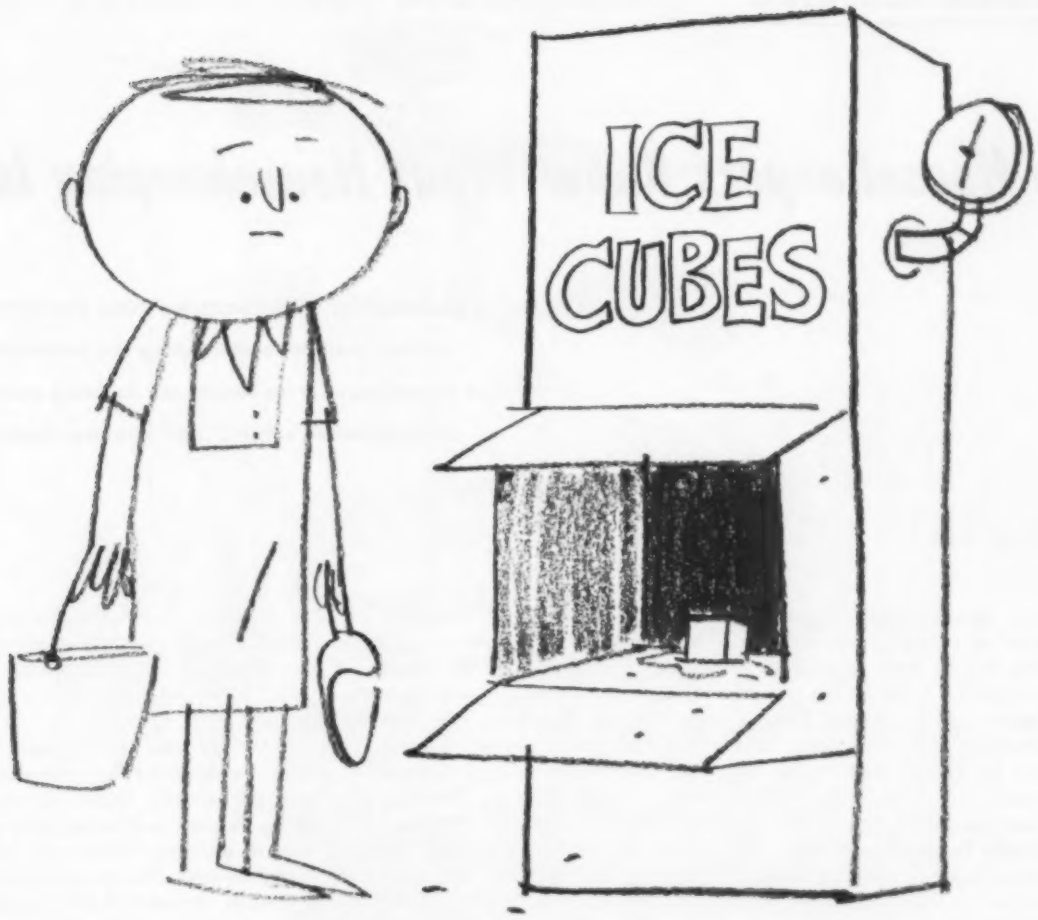
The hospital is well satisfied with both the new distribution method and the consolidation of linen items. Nurses have been freed from clerical work, and the per pound cost of laundering hospital linen has remained constant, although salaries have been increased. ■

New Products and New Procedures Both Helped Cut Laundry Costs

New one-piece uniforms (center) worn by nursing students are simple to launder. The preclinical students are furnished drip-dry pinafore and blouse, which they launder.



Laundry manager, Charles Cooney, watches as nurse's aide removes packs of linen for morning patient care while a laundry employe refills the surplus linen closet.



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Do Housekeepers Know What Housekeeping Is?

The responsibilities of the housekeeping department extend well beyond keeping the place clean. Three broad areas it embraces are building service, administrative control, and practical esthetics

David A. Gee

THE housekeeping department plays an unusual and often unenviable role in seeking to find its proper function in all of the activity that makes up the general hospital. Housekeeping functions are often dictated by factors over which the department has little or no control, and some on which it probably has never really been educated.

In most hospitals the housekeeping department is the second or third largest department in terms of numbers of personnel, ranking only behind nursing and sometimes dietary. It performs vital tasks that are the subject of much complaint when they are done poorly and taken for granted when they are done well.

Housekeeping Relatively New

Historically, housekeeping departments did not exist in hospitals. A hundred years ago, nursing personnel did the jobs of direct patient care, handled the patients' meals, and performed the cleaning tasks. Even 50 years ago this pattern was more or less prevalent, with just the first recognition that housekeeping was a function in itself.

From that time on the housekeeping function has grown and developed into an important organizational entity. However, this growth has not always been uniform. The hotel industry gave much greater recognition to this department than did hospitals. Hospitals are among our most complex organizations, not only because of the mass of interwoven technology, but also because of their difficult social structure. Hospital housekeeping did not move along at the same rate as it did in hotels, because housekeeping has not been considered a prime function in itself — it has always been subordinated to the needs of direct patient care activities.

In the growing complexity of the modern hospital, the housekeeping department that has set its sights on minimal functions will be lost in the press of many other more glamorous and exciting activities. Twenty-five years ago, industrial engineers urged specialization of activities so each job would be reduced to its simplest components. There is also recognition that consolidation of many activities has resultant economies of operation. With other departments proliferating in all directions, housekeeping has an opportunity to create an entire new complex of services for the hospital. By having as many functions as possible and as much diversification of skills as possible, the housekeeping department can justify the administrative organization it requires.

Hospitals are made up of a large number of small and discrete organizational entities. Each of these must be supervised and administered. If some of them can be combined organizationally, this means proportionately fewer administration requirements.

When one talks about specific functions for housekeeping departments, one immediately thinks of keeping the place neat and clean, plus some related activities. These are merely technical items that must be included in much broader basic functions. These functions can be characterized as follows: (1) building service, (2) administrative control, (3) practical esthetics.

Building Service

In the area of building services, it is possible to include activities such as all of the building cleaning functions, furniture control, linen distribution and control, sewing room production, and the like. These are functions that are associated with most hospital housekeeping departments.

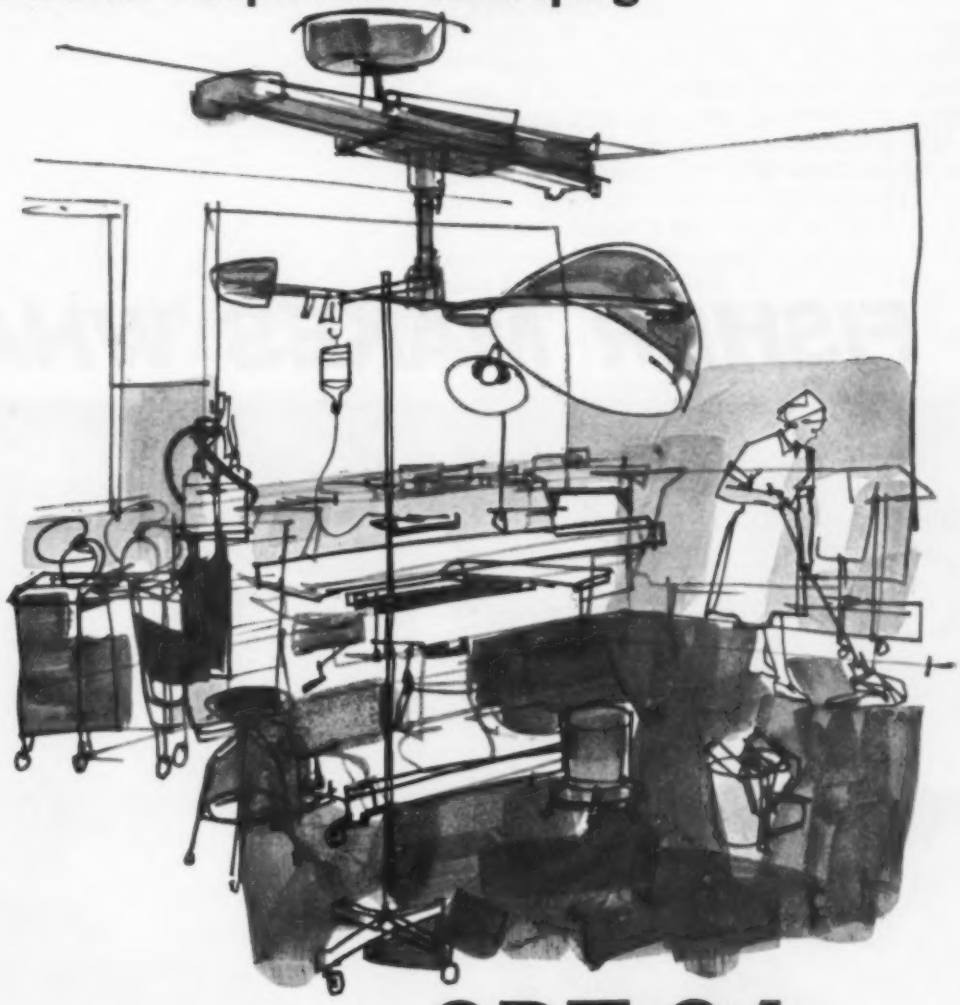
Another area is that of hospital decoration. A decoration committee headed by the executive housekeeper and including representatives of the purchasing department and possibly a member of the women's auxiliary broadens the scope of the department and permits it to influence the whole appearance of the hospital. Its possibilities are only limited by the imagination of its members.

Under the broad category of dec-

(*Continued on Page* 158)

David A. Gee is associate director, The Jewish Hospital of Saint Louis. This paper is part of a longer work presented to the Executive Housekeepers' Development Program, University of Florida, Gainesville.

...for better hospital housekeeping



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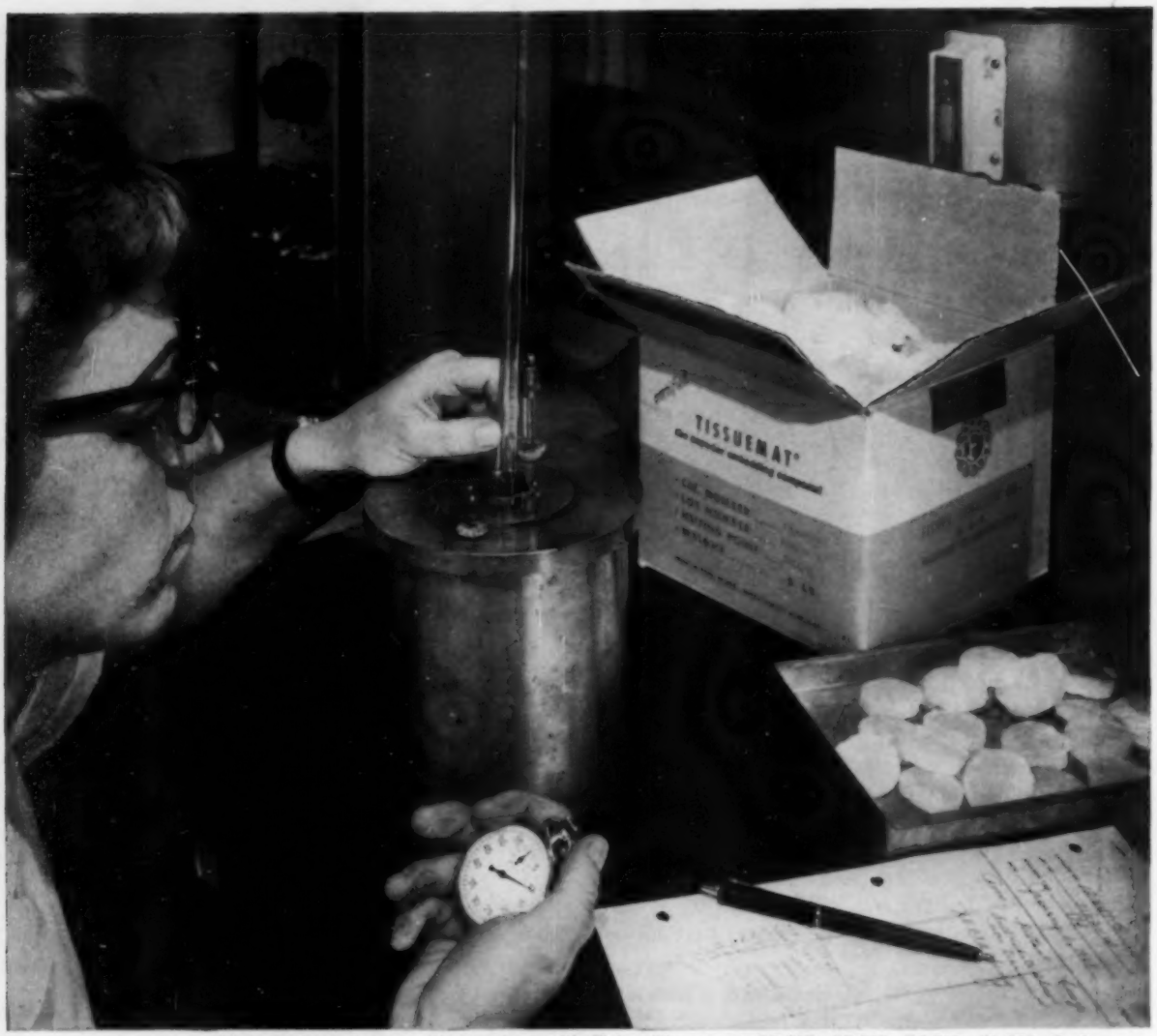

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(*Continued From Page* 154)
orations may also be considered work with architects and outside decorating consultants. Too often, the housekeeper is the recipient of flamboyant and impractical creations of high decor that are in a shambles within a few months' time. A good housekeeper understands *hospital* function and can intelligently advise decorators so the attractive appearance will last.

Should Supervise Painting

The hospital's painting crew may well be supervised by the housekeeper. Some plant engineers may argue this, but it cannot be denied that the housekeeper is in much better position to have a continuing liaison with the admitting office and nursing divisions — two of the key areas involved when it comes to scheduling painting.

Other building services are operation of the telephone switchboard, the message center, and receptionists, activities customarily found under the direction of the business office. Business offices in modern hospitals are becoming more and more absorbed with cost accounting, the use of computers, and better collection technics, and hence are not always as close to less technical operations. Is there any reason the housekeeping department should not expand into these areas?

Some more prosaic tasks such as keeping track of the vending machines or providing newspaper service can also be important functions and give housekeeping further entree to patient needs and problems.

More significant is the role of housekeeping in professional programs. On psychiatric floors, housekeeping employes must undergo special training so that they will interrelate with patients in the proper fashion. In institutions that use a therapeutic community approach, patients may actually perform their own cleaning tasks. Housekeeping has to be attuned to picking up the pieces and patiently learning how to work in what may often be a difficult situation.

Problems of infections control thrust the housekeeper directly into the center of professional activity. Many housekeepers are passive participants in their hospitals' infections control programs and carry out certain procedures whether they understand them or not. There is a substantial difference between these individuals and those who understand the problems of the spread of bacterial infection and who are contributing their special talents in working with professional personnel to achieve a satisfactory goal. There is a difference between merely augmenting cleaning activities and taking on the new function of being a knowledgeable partner in a hospital-wide program.

Hospital housekeeping departments are participating in organized home care programs by providing housekeeper and homemaker services to patients who need this help while undergoing treatment in their own homes.

Everywhere one looks there is some place that housekeeping can participate. The limitations on this are set only by the narrowness or broadness of the executive housekeeper's ability to fit her talents to hospital functions instead of making the hospital use only the housekeeping functions that the department has to offer.

Administrative Control

A second major function of the housekeeping department is administrative control.

This is a function that housekeeping shares with all other departments in the hospital. It involves preparing realistic departmental budgets, having proper staffing patterns, and carrying on inservice training programs for personnel.

It involves setting up work assignments to cover the needs of the institution in an efficient fashion. It means engaging in work simplification and doing continual methods analysis.

Practical Esthetics

Practical esthetics involves applying standards and quality control to all the "jobs" performed by the department.

Every building has a personality. Its architect designed it to meet the functions of the hospital: patient care, education, research and prevention. Usually architects do a good job; frequently, even with all their experience, they cannot foresee all of the physical requirements of our complex organizations. Be that as it may, what happens to the building esthetically after the architect has completed his task also affects the people who use the building.

One always gets some impression about the nature of the business from the particular building that houses it. A messy lobby with filled ashtrays and outdated magazines is not just a sign of poor housekeeping. It gives the visitor a feeling that all of the rest of the organization is just as sloppy.

Esthetics Requires Imagination

Practical esthetics is having imagination about the jobs one does and then taking pride in carrying them out. This is the housekeeper's most important function. The doctor takes pride in an operation well performed. The maintenance man takes pride in a good piece of workmanship. The housekeeper must have just as much pride in the appearance of the building.

Practical esthetics requires more than a good heart and the desire to have nice surroundings. It requires keen observation, dogged persistence in follow-through, and continual training of subordinates. It requires looking beyond one's nose, having an inquiring mind, and accepting responsibilities that sometimes are hard to live up to.

It is not uncommon to hear housekeepers say "Oh, I didn't see it" when one asks about the dented wastebasket or the crooked sign or the burned-out light bulb. These are the little things, but it is these little things that create an image for patients and the public.

Part of Solution, Not Problem

One hears hospital people complain about the housekeeping department. "Sure, the maid comes around to clean but it never looks quite right," they say. Attention to the function of practical esthetics makes the housekeeping department part of the solution instead of part of the problem.

Being part of the solution should be the goal of every hospital activity, and the housekeeping department is well equipped to be in the forefront in creating and executing meaningful functions that are of benefit to the patient and the hospital. ■

Tests of hospital linen show . . .

99.5% reduction in Staph count of soiled linens when SWIFT'S ENSTAPH is used

In tests conducted at five Chicago area hospitals, it was found that the use of ENSTAPH resulted in a 99.5% reduction in the *Staphylococcus* count of urine soaked diapers.

The diapers from hospitals using no germicides in their washing formulas showed an average *Staphylococcus* count of 5,460,000 per diaper—hospitals using ENSTAPH average only 25,200.

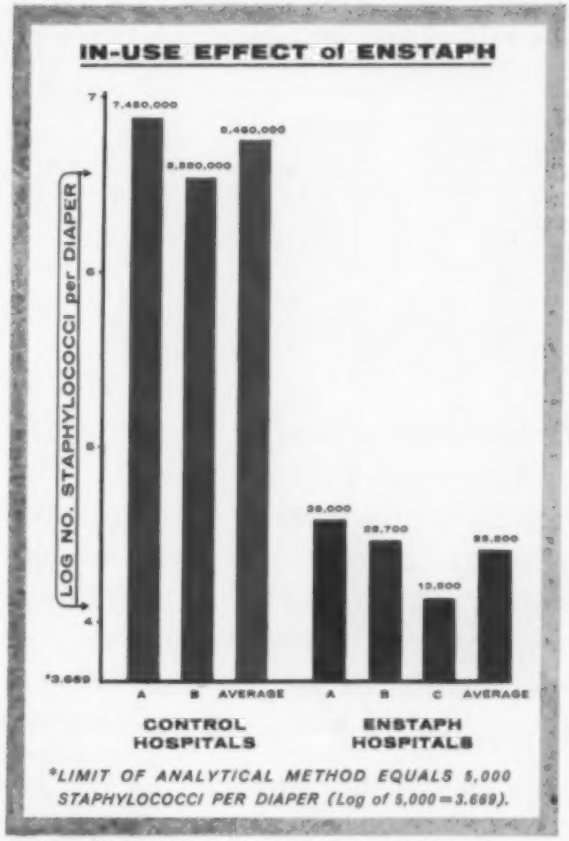
CONCLUSIONS

The results show the hazard that is created when linens soiled with fluids are held at temperatures permitting bacterial growth. *Staphylococcus* contaminated material becomes a focus of infection to the patient and *to the environment*, thereby to all patients and personnel. The regularity with which *staphylococci* can be found in soiled linens shows that the danger of an outbreak always exists.

THE ROLE OF ENSTAPH

Swift's ENSTAPH breaks the cycle of *Staphylococcus* transmission in linens. Fabric washed in ENSTAPH is impregnated with germicides which inhibit *Staphylococcus* growth at levels as low as 1 to 2 parts per million. Linens retain their anti-bacterial characteristics during dry storage. During use, when the cloth is moistened, the germicides are activated and exert their activity against contaminating *staphylococci*.

Our studies have shown that unprotected linens constitute a potential threat to the hospital environment. The use of ENSTAPH presents a solution to this problem. The hospital must decide whether it can afford to treat its linens with germicides in order to break the cycle of *Staphylococcus* transmission.



LET'S LOOK AT THE FACTS ABOUT COST AND USE

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Public Health Service Study: How To Keep Hospitals Quiet

(*Continued From Page* 87)

where the aforementioned facilities should be located in relation to patients' rooms. A closely related core of these facilities minimizes traffic outside the core and limits the traffic to that necessary for direct patient care. Of course, every effort should be made to have all types of equipment in these areas operate quietly. Sounds should not be transmitted to the structure or radiate through corridors.

Several steps can be taken to reduce the noise emanating from workrooms. As discussed earlier, achieving quiet in utility rooms begins with controlling the noise at the source by proper planning and selection of equipment that operates quietly. Sufficient, comfortable ventilation should be provided so that the doors to utility rooms and floor pantries can be kept closed while the staff is working. The type of work performed in these rooms, such as handling the utensils, involves essentially noisy procedures and equipment. However, if the staff must leave the doors open, or if louvered doors are provided for ventilation, all efforts to contain the noise in these rooms will be cancelled. In addition to providing mechanical ventilation, hospital planners should see to it that the doors are well fitted and gasketed.

The next step would be to treat the rooms with acoustical material. The use of acoustical materials throughout the entire nursing area, including the patients' rooms, will considerably reduce the noise levels in all patients' rooms from all sources.

Planning for Noise Control

Much can be done about controlling noise by skillful arrangement of the interior areas as they relate to the internal traffic patterns and by the use of sound absorbent materials, double walls, or materials having a high sound transmission-loss factor.

High-level noise sources should be isolated by locating them in remote areas or, when this is not feasible, by providing appropriate construction to screen the noise from patient areas. Such construction must be well designed, completely free of cracks or openings and unsealed holes for heating or plumbing lines, so that noise cannot be transmitted to adjoining areas. It should be thoroughly examined and rechecked for any gaps that may develop.

Planning for effective noise control need not be a formidable undertaking or involve high costs. It does add to the responsibilities of the architect, engineer or manfacturer to ensure: that the structural and mechanical functions of the hospital building and equipment are designed and installed to operate quietly; that conditions are provided to enable employes to perform their work in comfort, and that the environment helps to dispel conditions that contribute to noise.

Such a program does not stop with the emphasis on good design of buildings and equipment; it is also an administrative and personnel responsibility.

Just as it is significant to obtain efficient mechanical function of equipment and structural components, so is it important to cultivate the concern of all staff members to help avoid excessive noise that may accompany their activities. Through these combined efforts, it is possible to achieve an optimum quiet environment in hospitals. ■

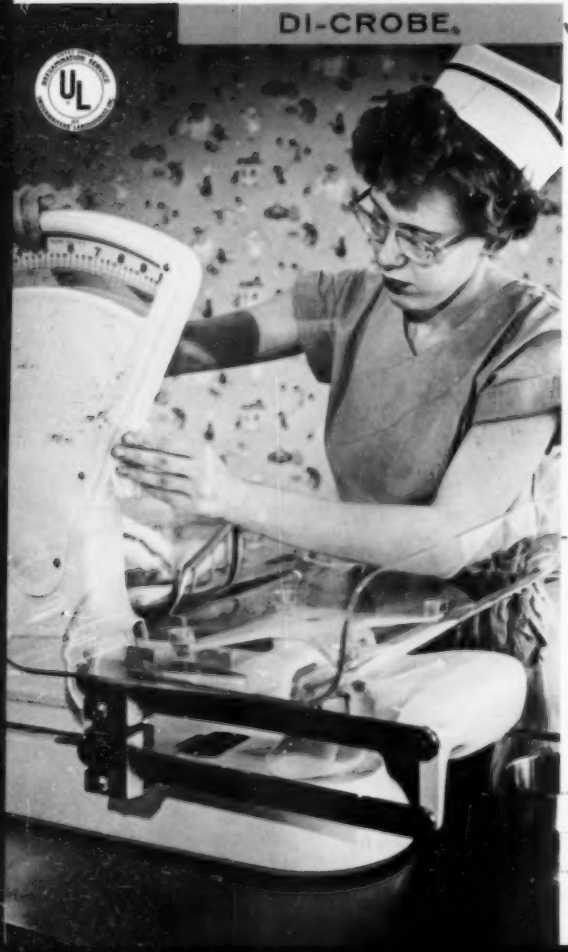
This nursery is virtually free of disease-causing bacteria! And he helped make it that way!

He's the Man Behind the Huntington Drum (our representative). And his recommendations for a Patient-Safety Program are helping protect everyone in this nursery from cross infection. The program is based on his years of experience and a multitude of sanitation products especially created to meet the aseptic requirements of hospitals. Read about this important program on the next page. It's the common-sense solution to the problem of hospital-acquired infection.

HUNTINGTON

... where research leads to better products

HUNTINGTON LABORATORIES • HUNTINGTON, INDIANA • Philadelphia 35, Pennsylvania • *In Canada:* Toronto 2, Ontario



The Huntington Patient-Safety Program

How to prevent infection from originating in the hospital. That's the problem. Many hospitals are solving it by returning to old-fashioned attitudes toward cleanliness in every department combined with the use of modern, efficient aseptic products. And they are adopting the basic principles of a Patient-Safety Program to set up a common-sense plan-of-attack against resistant Staph. and all other infectious agents.

This practical program features:

- More than 100 Huntington products that will effectively help combat the spread of infection from the admitting office to the O.R. suite, the nursery, everywhere in the hospital.
- An intelligent Huntington representative to help you plan the program to meet your specific needs. Individual hospital aseptic problems differ because of variations in layout, in function and in use. The job of the Man behind the Huntington Drum is to select the right Huntington product or products for your hospital. He will show you how to efficiently and effectively use these products to destroy bacteria on all surfaces.
- An experienced Huntington representative whose advice and suggestions will greatly assist you while building and maintaining your Patient-Safety Program. His experience in the hospital aseptic control field averages 19 years.
- A company that completely backs up its men and products with research laboratories that place quality above all else. For over 41 years, these laboratories have been enforcing rigid control over the Huntington manufacturing processes.

Call or write today. Get more details on the Huntington Patient-Safety Program.

Prevent cross-infection in the nursery with these two Huntington products:

- **HEXA-GERM ANTISEPTIC SKIN DETERGENT WITH 3% HEXACHLOROPHENE** • Proven effective in preventing Staphylococcal skin infections in the newborn nursery. Excellent for removing vernix and preventing pyogenic skin infection. Economical in use, Hexa-Germ is widely accepted in hospitals for pre-operative surgical hand-washing and as a routine hand wash for all personnel. Regular use leaves a bacteriostatic layer on the skin. Blended with skin-conditioning lanolin and petrolatum.
- **DI-CROBE GERMICIDAL CLEANER DISINFECTS, DEODORIZES AND CLEANS IN ONE EASY STEP** • A *soapless* (anionic) detergent and a *phenolic* germicide combined. Bactericidal under use conditions. Kills a broad spectrum of microbes, including resistant Staph., at very high dilutions. Leaves an anti-bacterial blanket if not rinsed. Effectively lowers bacterial count in the air when sprayed. Will not create a soap film, UL approved for use on conductive floors. Non-toxic and non-irritating. May be used on all surfaces not harmed by water alone.

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- ☐ Please send me the free booklet, "A Suggested Plan for Infection Control in Hospitals."
- ☐ Send more information on Hexa-Germ Antiseptic Skin Detergent.
- ☐ Send laboratory reports and other literature on Di-Crobe Germicidal Cleaner.
- ☐ Have your representative call for an appointment.

NAME _____ TITLE _____

HOSPITAL _____

ADDRESS _____

CITY _____ STATE _____

How To Plan and Finance a Nursing Home

(*Continued From Page* 115)

common stock, preferred stock, and/or debenture bonds. This decision can only be made by each corporation as the individual needs dictate. All stocks, of course, must be registered with the state Securities Exchange Commission. If a majority of this work is done before application is made for a loan, the chances of success will be increased.

The ease or difficulty of obtaining the necessary loan will depend upon several circumstances. Often if the need for a nursing home is keenly felt in the community, application to the local bank or savings and loan organization will be all that is necessary. Of course, the size of the community will have a considerable bearing on this possibility. At any rate, the local bank is the best place to start the search for funds. If it turns down the application, there are other possibilities, such as insurance companies, savings and loan companies, brokers who sell first mortgage bonds, the Small Business Administration (see page 109), and the Federal Housing Authority.

It is always a good idea to keep the local bank in mind even it if has not approved the first request. Commitments from other leading agencies are often easier to acquire if the bank will participate to even a small degree in the loan. No one source of first mortgage money can be considered better than another because conditions vary so much from area to area.

Success or failure in obtaining the needed funds may very well be determined by the soundness of the plan presented by the applicant. The first impression he makes when he sits across the desk from the loan examiner may be the last if he cannot convince the examiner that he knows what he is talking about and that his project has been carefully worked out. It is good to have documented evidence of need from such agencies as the state health department, the state welfare department, local physicians, and any others who are in a position to know what facilities are needed in the area.

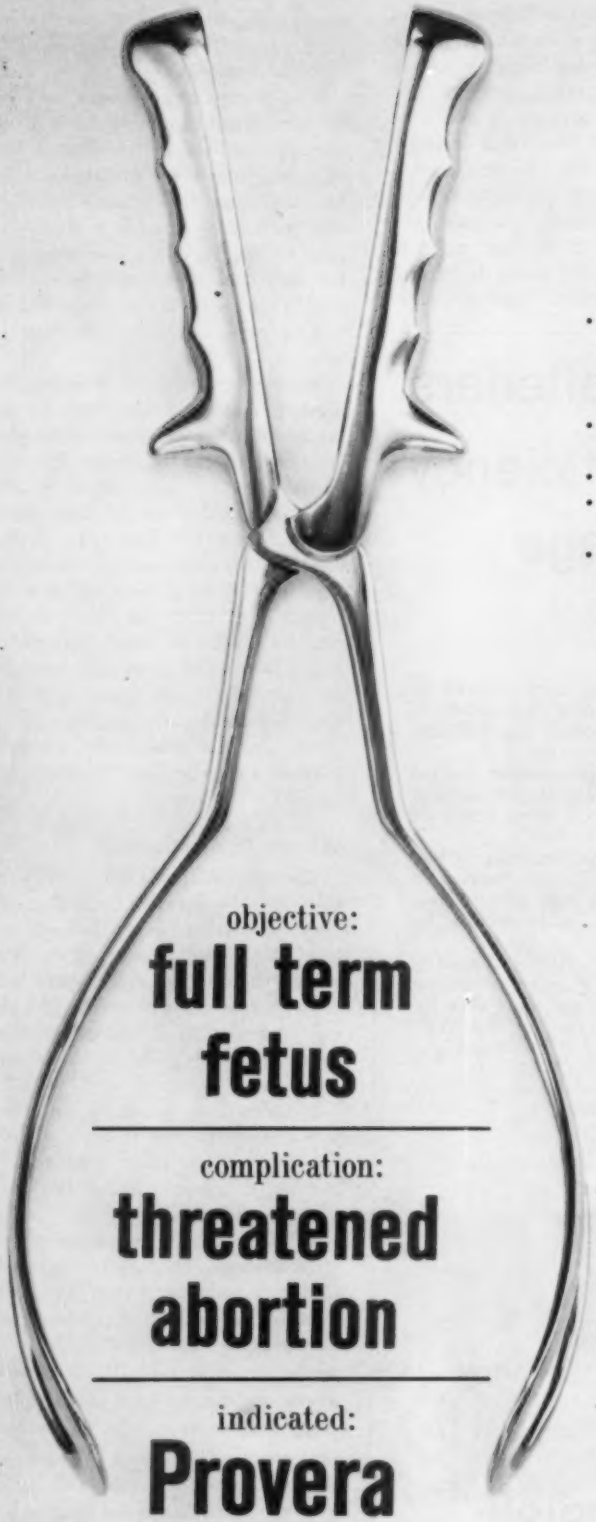
Lessons To Be Learned

Throughout the whole process of selecting the location, planning the building, setting up the budget, and obtaining funds, the prospective owner should use every spare moment to visit other new and old nursing homes to avail himself of their experience and profit by their mistakes.

Mistakes are inevitable in every new enterprise, but there is no reason to fall into errors that can be avoided by observation of the operation of other homes.

Finally, the nursing home owner must examine his motives in establishing a nursing home. Certainly, nonprofit as well as proprietary facilities must earn more than bare expenses if the home is to continue in operation, but the goal of the enterprise must be more than simply making money. There must be a sincere desire to serve the sick and aged.

If the owner's interest is primarily mercenary, he should direct it into some channel other than the field of medical care. ■



objective:

full term fetus

complication:

threatened abortion

indicated:

Provera

Upjohn

Here are five reasons why:

- Provera is the only commercially-available oral progestational agent that will maintain pregnancy in critical tests in ovariectomized animals.
- It is four times as potent (by castrate assay) as any other progestational agent.
- No significant side effects have been encountered.
- It is available for both oral and parenteral administration
- Provera gives the economy of effective action from small doses.

Brief Basic Information

	●Oral Provera*	←— I.M. Depo-Provera**
Description	Upjohn brand of medroxyprogesterone acetate.	Aqueous suspension, 50 mg. Provera per cc., for intramuscular injection only.
Indications	Threatened and habitual abortion, infertility, dysmenorrhea, secondary amenorrhea, premenstrual tension, functional uterine bleeding.	Threatened and habitual abortion, endometriosis.
Dosage Threatened abortion	10 to 30 mg. daily until acute symptoms subside.	50 mg. I. M. daily while symptoms are present, followed by 50 mg. weekly through 1st trimester, or until fetal viability is evident.
Habitual abortion		
1st trim.	10 mg. daily.	50 mg. I.M. weekly.
2nd trim.	20 mg. daily.	100 mg. I.M. q. 2 wks.
3rd trim.	40 mg. daily, through 8th month.	100 mg. I.M. q. 2 wks. through 8th month.
Supplied:	2.5 mg. scored, pink tablets, bottles of 25; 10 mg. scored, white tablets, bottles of 25 and 100.	Sterile aqueous suspension for intramuscular use only. 50 mg. per cc., in 1 cc. and 5 cc. vials.†

Precautions: Clinically, Provera is well tolerated. No significant untoward effects have been reported. Animal studies show that Provera possesses adrenocorticoid-like activity. While such adrenocorticoid action has not been observed in human subjects, patients receiving large doses of Provera continuously for prolonged periods should be observed closely. Likewise, large doses of Provera have been found to produce some instances of female fetal masculinization in animals. Although this has not occurred in human beings, the possibility of such an effect, particularly with large doses over a long period of time, should be considered.

Provera, administered alone or in combination with estrogens, should not be employed in patients with abnormal uterine bleeding until a definite diagnosis has been established and the possibility of genital malignancy has been eliminated.

†Each cc. of Depo-Provera contains: Medroxyprogesterone acetate, 50 mg.; Polyethylene glycol 4000, 28.8 mg.; Polysorbate 80, 1.92 mg.; Sodium chloride, 8.65 mg.; Methylparaben, 1.73 mg.; Propylparaben, 0.19 mg.; Water for injection, q.s.

The Upjohn Company, Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF. **TRADEMARK

Hospital With Emergency Care Must Provide Best Service It Can

(*Continued From Page* 116)

for treatment. It should be remembered that juries are usually composed of laymen unfamiliar, and generally unsympathetic, with the complexities of providing hospital care.

What limitations can a hospital place upon the operation of its emergency service with respect to the hours when the service will be open? Does the hospital run any legal risk if it closes its emergency room from, perhaps, 11 p.m. to 8 a.m.?

Although there are no cases on this subject, since no common law legal duty to provide emergency care exists, it is likely that a hospital with an emergency service would be able to regulate freely the hours when it would be available to the public, without risk of liability if it did not provide 24 hour service.

Certainly, sound reasons may require a decision that the emergency room not be open constantly. Staff may be insufficient in number to provide continuous trained and competent coverage. The cost of providing round-the-clock service may be too great. Or, other hospitals in the vicinity may have sufficient facilities to provide adequate emergency coverage during nonpeak hours.

One note of caution should be added. The hours when emergency care is available should be posted and the information should be made common knowledge in the community. Then, an injured person is less likely to rely on the hospital for 24 hour-a-day emergency care. It is difficult to assess what weight a court might give to such reliance where a closed emergency room denied an injured person the opportunity to go elsewhere for emergency treatment, and where the fact that the hospital did not oprate a 24 hour-a-day emergency service was not publicized.

Often, the question arises as to whether consent of the patient is necessary before emergency treatment is begun. When the person who comes to the emergency room for treatment is conscious and competent, it is always preferable to ask that he sign a consent to treatment. However, the very nature of the care sought, that is, the fact that it is emergency care, often renders this course of action impracticable.

When an emergency exists which requires the immediate action of the hospital or physician to preserve the life or prevent impairment of the health of the patient, and it is impossible to obtain the patient's consent, or someone legally authorized to consent for him, emergency care may be undertaken without liability for failure to procure consent. Thus, if an unconscious person is brought to the emergency room, treatment can be begun without delay. The same would be true if the person was not unconscious but was otherwise unable to give meaningful consent.

In no case should emergency care be postponed while formal consent is sought. If there is time to procure a written consent while medical care is being summoned, this should be done. However, when a person presents himself at the emergency room for care he voluntarily submits himself to medical treatment. The fact of voluntary submission will usually be sufficient to establish a valid consent. It should also be remembered that the consent of a person in great pain may be entirely worthless if it can be shown that the person was unaware of what he was signing. ■

The Modern Hospital News Digest

If You're Not Accredited, You Can't Join, Blue Cross Tells Hospitals in New York

Nonaccredited hospitals here can no longer join Blue Cross. Such hospitals that are already participating in the N.Y. plan will have three years to become accredited, plan officials indicated. Earlier, J. Douglas Colman, president of the plan, defended the N.Y. Blue Cross salary structure in testimony presented to members of the state legislature. ***(Page 176)***

Fires Teach Hospitals a Vivid Lesson: Vigilance and Training Are Price of Safety

Several recent fires in health care institutions brought death and destruction, but also proved again that proper training in evacuation and safety technics can pay off when preparedness counts most. ***(Page 171)***

Pittsburgh Plan Designed To Take Confusion Out of 'Expert Medical Testimony' for Courts

The "battle of experts" over medical testimony — which often results in widely divergent claims that serve only to confuse the jury — may be eliminated in Pittsburgh by a panel system. ***(Page 172)***

Boric Acid Results in Five Deaths After Formula Error in Canadian Hospital Nursery

A labeling error was blamed for the deaths of five infants at Grey Nuns Hospital, Regina, Sask. Dr. J. A. DuPont, medical superintendent, said the babies became ill after being given a formula that contained boric acid solution instead of distilled water. Police and hospital officials are investigating how the poisonous solution came to be in the jugs normally used for water. ■

Loss of Foreign Interns Forces Stop-Gap Staffing, Hospital Survey Discloses

NEW YORK. — Hospitals are having to take "extraordinary measures" to meet staffing shortages caused by the loss of almost 2500 uncertified foreign medical graduates, a countrywide survey disclosed.

The survey, undertaken by *The House Physician*, showed that attending staffs, technicians, senior medical students, and even full-time practicing physicians are being used to fill the gaps left by foreign graduates who failed the required examination in September.

Here are some of the extraordinary measures reported by hospitals in the survey:

— Attending physicians are being used in emergency wards on regular, rotating schedules. Some busy emergency rooms are "borrowing" physicians from near-by hospitals.

— Surgeons are being asked to provide their own assistants for operations.

— Additional staff is being hired. Some cities are seeking to put practicing physicians on the payroll for part-time employment and hope to hire others full time.

— "Externs" are doing some of the work of interns, although they are not permitted to write orders.

— In increasing numbers of hospitals, third and fourth year medical students are being allowed to take histories and do physicals, under supervision.

Hardest hit, the report said, are city, state, county and small voluntary hospitals in the Midwest, parts of the South, and in New York.

In most of the affected hospitals, the graduates who failed the last examination were retained in non-patient care areas after the January 1 deadline and are taking brush-up courses in medicine and English to prepare for the next test.

Administrators in severely affected hospitals were quoted as saying: "We're up against it," and "I just don't know what we'll do."

However, support was frequently voiced for the E.C.F.M.G. requirement, along with a recognition of the difficulties entailed.

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DIVERTER VALVE

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ELIMINATES...

- ✓ High installation costs
- ✓ 2 or 4 adjustment valves
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- ✓ Extra piping
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The routine task of bedpan cleaning and rinsing is made easier . . . and done in less time with the improved American-Gray Diverter Valve. *A welcome convenience by nursing personnel,* the valve is operated by a mere trip of the regular flushing handle . . . diverting a perfect spray of fresh water through the nozzle and into the utensil . . . *no leaky hoses, hot and cold valves or awkward piping and pedals.*

Cost-conscious administrators like its *simple, low-cost installation, minimum maintenance and time-saving features.*

The polished chrome finish is as handsome as the fixture is efficient. The Diverter Valve becomes an attractive integral part of the toilet assembly, eliminating bothersome fixtures.

Modern in every way, the improved American-Gray Diverter Valve eliminates awkward hoses where leaks are both dangerous and annoying . . . and the operator always has perfect balance with no "teetering" on one foot. Acceptable under the most rigid plumbing codes, thousands of these American-Gray Diverter Valves are saving hours and dollars in hospitals and nursing homes throughout the world. Installation is simple with the Valve being placed *between* the existing flush valve and the toilet . . . permanently.

• *Easy—Economical to Install*

World's largest Designer and Manufacturer of Surgical Sterilizers, Tables, Lights and related equipment

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

For additional information, use postcard facing back cover.

Louisiana Hospitals Elect Clifford C. Losberg Jr.; Hear Two Groners Speak

SHREVEPORT, LA. — Clifford C. Losberg Jr., assistant director, Ochsner Foundation Hospital, New Orleans, was named president-elect of the Louisiana Hospital Association at its 36th annual meeting here last month.

Mr. Losberg will succeed J. B. Heroman Jr., assistant administrator, Our Lady of the Lake Hospital, Baton Rouge, who became president during the meeting. Dr. W. R. Hargrove, Oakdale, was the retiring president.

Hospitals and physicians have been too defensive in their public attitudes toward the problem of mounting medical costs, Pat N. Groner, administrator, Baptist Hospital, Pensacola, Fla., said in a major address to the convention.

"We automatically assume the defensive in the face of any challenge concerning the expense of medical care," Mr. Groner said. "Instead, we should think of new ways in which we can enlighten the public on the many benefits that good health care brings to our economy."

Mr. Groner presented detailed information showing that increases in health care costs were in line with changes in the national economy.

In another address at the convention, Frank S. Groner, LL.D., president of the American Hospital Association, said the proposed national program for health care of the aged under social security would be a step toward "compulsory health insurance and the welfare state."

The social security proposal would be more costly than has been estimated, Dr. Groner said, and would have an adverse effect on patterns of hospital care.

"Government is going to be interested in the cost of care, and it should be," Dr. Groner said, "but quality would become a secondary consideration under the social security plan."

More than 600 members of the association and related groups were registered at the convention, Charles R. Gage, executive director, reported, making it the largest meeting in the association's 36 year history.

E. M. Bluestone Receives A.H.A. Service Award

CHICAGO. — E. M. Bluestone, M.D., has been chosen to receive the American Hospital Association's Distinguished Service Award for 1961.

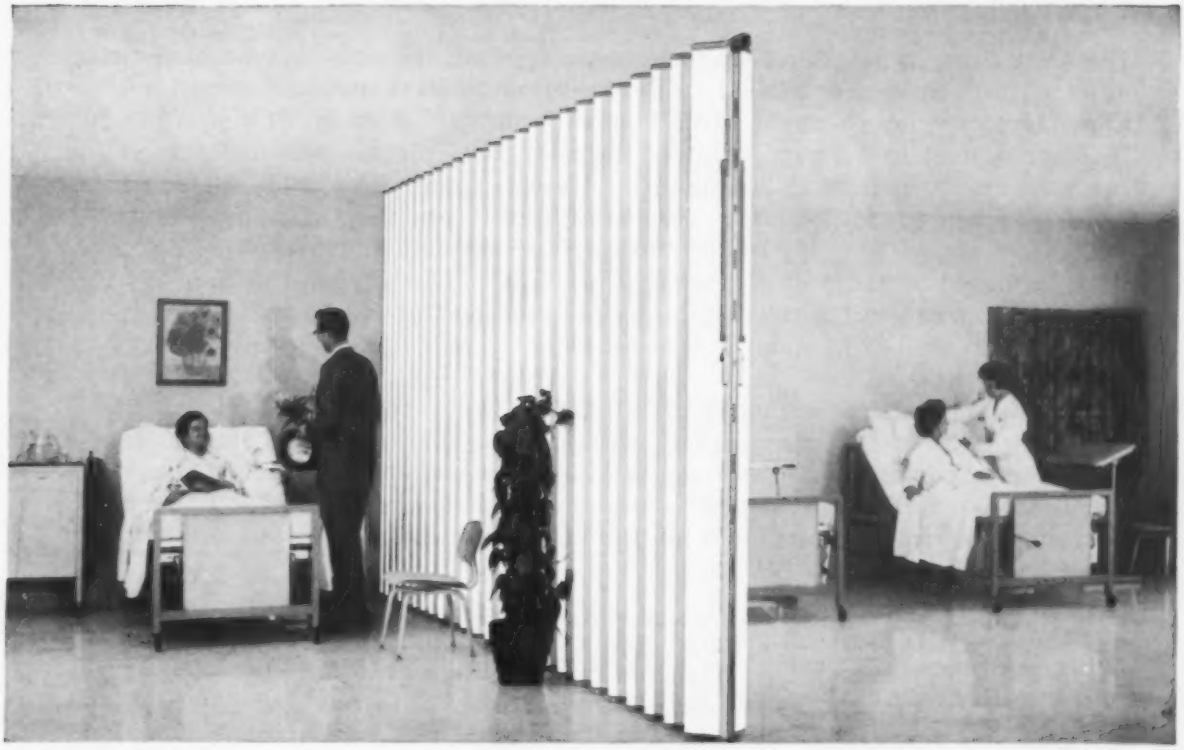
Dr. Bluestone

Dr. Bluestone, director of Montefiore Hospital, New York, for 22 years until his retirement in 1951, has stressed the need for individualizing the care of patients. A consultant on many national and international health field projects, he is recognized as a leader in developing hospital based home care programs.

He is a representative of the International Hospital Federation to the United Nations and a member of the expert panel on organization of medical care of the World Health Organization. He is assistant professor of hospital administration at Columbia University and professor of public administration at New York University.

(*News Continued on Page* 171)

Certified* to shut out sounds other partitions let through



*Decibel ratings by Geiger & Hamme Laboratories per ASTM E90-55

New! Steel-Walled Modernfold

● *First in sound reduction . . . first in heavy-duty hospital design.* To close off private rooms in wards, to create emergency rooms on an instant's notice, or to divide any area to double your use of existing space . . . you'll find this Soundmaster 240 by Modernfold rivals conventional walls in sound control, yet still lets you reunite divided space for complete flexibility.

The heart of Modernfold's sound superiority is in twin walls of steel panels beneath that luxurious vinyl . . . a dense, rigid barrier with eight sound-stopping horizontal edge seals custom-trimmed to the opening.

But this five decibel lead in sound control is only half the story. Because no other partition in the industry matches Modernfold heavy-duty construction. The chart at the right shows you why . . . comparing Modernfold's Soundmaster 240 with the *best* model offered by each of the next largest manufacturers.

Partition	"240"	"A"	"B"	"C"
*Sound Reduction 125/4000 cps av.	37.4	32.4	31.8	27.9
354/4000 cps av. (Industry Standard)	41.8	35.8	36.4	33.0
Acoustic Panels	steel 5⅛" wide, wt. 1 lb./sq. ft.	uses cardboard	steel, 2⅛" wide, wt. ½ lb./sq. ft.	uses cardboard
Sealer Strips	8	8	4	4
Foam-Lined Jamb-Seal	yes	yes	no	no
Air Release	yes	no	no	no
Pull-In Latch	yes	yes	no	no
Best Fabric Weight—Outside Covering Only	45 oz. per lin. yd.	45 oz. per lin. yd.	18 oz. per lin. yd.	27 oz. per lin. yd.
Top Row Horizontal Hinge Plate Depth	8½"	3"	(vertical)	1½"

NEW CASTLE PRODUCTS, INC.
Dept. H-441, New Castle, Ind.

Gentlemen: Please send full information on Soundmaster 240.

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CITY _____ STATE _____

NEW CASTLE PRODUCTS, INC.
NEW CASTLE, IND.

Manufacturers of Modernfold Partitions and Doors, Air Doors, Modern-Cote Wall Coverings, Peabody School Furniture and Pyrox Sheathed Thermocouples.

In Canada: New Castle Products Canada, Ltd., St. Lambert, Que.

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Air-Shields, Inc.
Hatboro, Pennsylvania

Gentlemen:

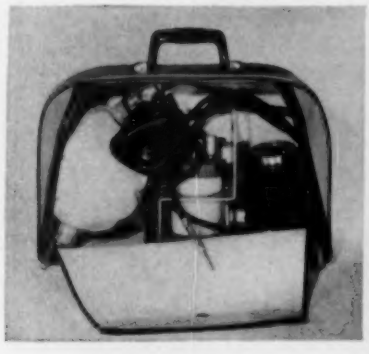
The Ambu Rescue Breathing Equipment you sold me recently has enabled me to save a life. November 25, as I was completing an otherwise routine appendectomy, my patient's heart suddenly stopped beating. Using a chest incision and manual compression of the heart, circulation was maintained and heart function returned in 20 minutes. He was then transferred by plane to a major hospital for further care. We were able to use the Ambu Resuscitator which had arrived the day before, to maintain manual respiration for 2 hours until he could be put on a mechanical respirator. An oxygen line was led to the resuscitator so that oxygen could be supplied throughout the flight.

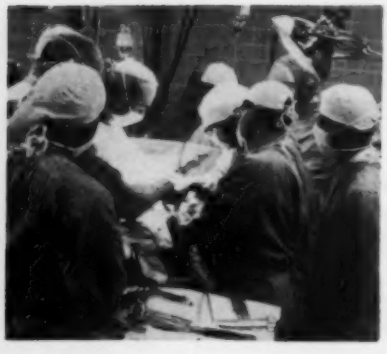
The ambulance which met us at the airport had received their Ambu unit the day before, the major hospital had also just received one, and the surgeon called in to perform a tracheotomy had also just purchased one. At the hospital we used their foot pump since I had not taken mine. The doctor who performed the tracheotomy said he tested his unit every day, but had not yet used it.

Without this compact resuscitator the trip would not have been possible, and this life would have been lost.

Sincerely,

----------, M.D.





Acknowledgement: We acknowledge the ever-present encouragement, help and associations that have enabled Air-Shields, Inc. to develop **products that help doctors save lives.**

AIR-SHIELDS, INC.

A Division of National Aeronautical Corporation, **Hatboro, Pennsylvania, OSborne 5-5200**

Recent Hospital Fires Point Up Need for Teaching Safety, Evacuation Technics

CHICAGO. — Fires in patient care institutions provided a solemn reminder of the need for fire safety and evacuation practice.

Lt. Robert McGrath, head of the Hospital Defense Program, which specializes in training hospital personnel in fire safety technics, pointed to several such incidents in recent months.

Most disastrous was a blaze which killed seven bedridden patients when it quickly engulfed a private nursing home in Washington, D.C. At least 27 other persons — patients, employes, firemen, policemen and passers-by who aided in rescuing the 17 other patients — were treated in hospitals. Fire Chief Millard H. Sutton termed it "one of the worst fires in years" in the city.

Eighty patients from the psychiatric section of Michael Reese Hospital, Chicago, had to be evacuated after fire broke out in a basement linen storage room.

Dense smoke was carried through the four-story building, which is separate from the rest of the hospital, the *Chicago Tribune* reported.

The patients, many of them in nightclothes and wrapped in blankets, were led to the main hospital building a block away by the more than 70 doctors, interns and nurses who responded to the evacuation alarm. Evacuation was completed in less than 15 minutes, according to Peter Johnson, assistant director of the institution.

Damage from the fire was estimated at $5000.

The fire was confined to the basement room, but firemen had to cut through the floor of a first floor reception room to reach the flames it was reported.

At La Crosse, Wis., a disaster evacuation plan worked smoothly at Lutheran Hospital when about 100 patients were moved safely when fire destroyed an old wing of the institution. The patients were taken to other wings of the hospital within 10 minutes of the time the fire was discovered.

"We have practiced constantly for evacuation of any wing of our hospital in the event of an emergency," L. R. Widmoyer, assistant hospital administrator, reported. "Our disaster evacuation plan worked beautifully. We didn't have an injury or loss of life."

Cost to replace the wing was estimated at $1 million.

Fire and water caused an estimated $12,000 damage at Midland Hospital, Midland, Mich. The fire started when sparks from a welding machine set fire to the paper covering of insulation in the crawl space above a hallway. The fire was extinguished by the hospital's automatic sprinkler system, which released volumes of water and caused much of the damage, the hospital reported.

"There was no danger at any time from the fire," according to Bernard Lorimer, hospital administrator.

Lesser fires were experienced recently at a building housing offices and an outpatient clinic of University Hospital, Baltimore, and at a cottage for 30 women at Manteno State Hospital, Kankakee, Ill.

Hospital Care Follows the Patient Home; Expect Plan To Save 29 Beds

GASTONIA, N.C. — A new home care program is expected to release 29 additional beds for inpatients at Gaston Memorial Hospital here. The program, which will be part of a progressive patient care system, will permit some patients to go home while still providing them with essentials of hospital care.

The hospital plans to send a specially designed bed to the patient's home; specially trained nurses and medical social workers will visit the home periodically, give medicine, dress wounds, check on progress, and instruct the family on how to care for and feed the patient, according to a report in the *Charlotte Observer*. Proposed rate for this service is $2.50 per day.

The plan was developed after a survey showed that on any given day about 30 persons in the hospital could be sent home on a home care program, the *Observer* reported.

The 207 bed institution is now switching to the five-stage pattern of progressive patient care, plus separate pediatrics and obstetrical units, according to Fred C. Hubbard, administrator. The conversion is expected to be complete next year.

UNICEF Midwifery Program Gets Children Off to a Good Start

Children in many remote parts of the world are being given a better start in life through the midwifery program of the United Nations International Children's Emergency Fund. National schools, established with help from UNICEF, attempt to solve the problems posed by high birth rates and lack of hospital facilities by training midwives in modern maternal and child care technics. Practicing what they have learned is not an easy task—as these pictures indicate. Left: A midwife gives the wife of a Thailand rickshaw driver instructions for caring for her week-old infant and checks his growth, using a miniature scale provided, along with other equipment, by the fund. Right: Midwives on horseback prepare to negotiate difficult terrain in back country of Paraguay. They were trained by UNICEF, which also supplies them with simple midwifery kits and, in addition, provides them with a small salary.

Panel of Medical Experts To Provide Impartial Testimony for Pittsburgh Courts

PITTSBURGH. — A plan to prevent medical testimony from becoming a "battle of the experts" has been devised by physicians here and approved by the federal court.

The plan for court appointment from a panel of physicians is intended to prevent introduction of slanted medical opinion and conflicting or misleading testimony, the *Pittsburgh Press* reported.

The Allegheny County Medical Society has long been eager to solve problems posed by so-called "professional medical witnesses" whose testimony may be colored to assist their clients, stated Dr. J. Everett McClenahan, chairman of the medical society committee that drafted the plan.

Here is how its founders say the system will operate:

The medical society will name a panel of examining physicians for the court after consultation with a committee appointed by the county bar association.

In any case involving the physical or mental condition of a litigant, the judge or either side may request an impartial medical expert.

This expert would be selected from the panel, probably by a medical officer designated as a deputy of the court. Physicians would be supplied through a rotation system.

The selected doctor would examine the subject, analyze medical phases of the case, and present his results to attorneys for both the plaintiff and defendant and to the judge.

These reports could be used in pretrial conferences to mediate and settle suits out of court.

If the case does go to trial, the physician could be called as an expert and would be identified as the court's own impartial witness.

Dr. McClenahan said similar plans in New York, Chicago and Philadelphia have been especially helpful in settlement of "hard core" cases — those involving widely divergent medical claims.

N.L.N. Regional Office Is Opened in San Francisco

SAN FRANCISCO. — The first branch of the National League for Nursing was opened here March 15.

Irene B. Miller, former director of the N.L.N. nurse recruitment program, is director of the office. Assisting Mrs. Miller is Ann Kent, administrative secretary. Miss Kent was also associated with the national headquarters staff of the League in New York.

NEW A.C.M.I. STERILE DISPOSABLE URETERAL CATHETERS

For the patient: Freedom from catheter-borne infection.
For the hospital: Freedom from catheter-handling drudgery.

A.C.M.I. Sterile Packaged Ureteral Catheters, designed to be used once and then discarded, protect the patient from catheter-borne infection, and relieve nurses and hospital personnel of time-consuming washing, rinsing, sterilizing and maintenance of catheters in sterile storage.
Other advantages:

- Ready for instant use
- Smooth, highly polished surface
- High flow rate through large, smooth lumen
- Eye openings smoothly finished
- X-ray graduations clearly marked
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Supplied in half-gross cartons.

Sealed sleeve easily opened by peeling back tabs without touching catheter.

American Cystoscope Makers, Inc.
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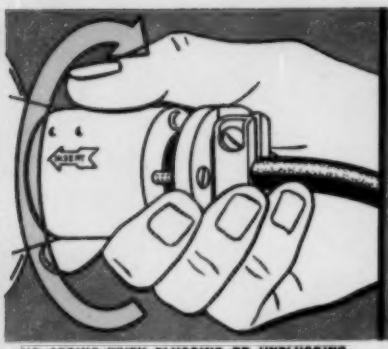
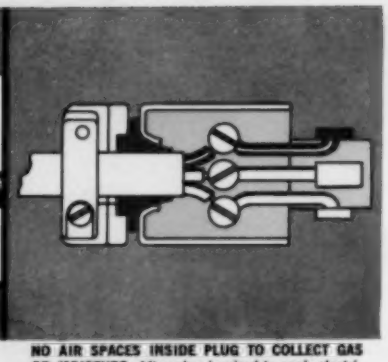
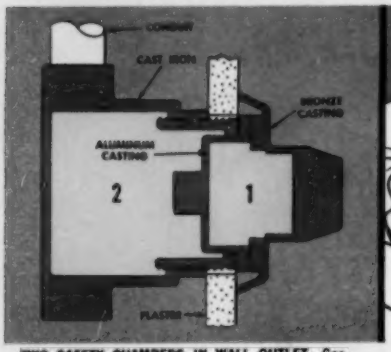
Catalogue Nos.
2001 SP — Whistle Tip
2003 SP — Olive Tip
2005 SP — Round Tip
Sizes: 4 to 10 Fr.



NO ARCING WHEN PLUGGING OR UNPLUGGING. Outlet is electrically "dead" until plug is inserted and rotated 22-25°. Reverse turn disconnects current before plug is removed. Spring pressure and keyed construction prevent accidental disconnection.



NO AIR SPACES INSIDE PLUG TO COLLECT GAS OR MOISTURE. After plug is wired to cord, electrician pours a self-hardening insulating resin into all air spaces. Interior of plug becomes solid, water-tight, vapor-tight mass.



TWO SAFETY CHAMBERS IN WALL OUTLET. Gas-tight chamber No. 1 (bronze and aluminum castings) contains and seals off switching mechanism. Cast iron chamber No. 2 keeps minor internal explosions from spreading to room.

PLUG CAN BE WASHED WITHOUT DISMANTLING AND REWIRING. Operating room soilage quickly and easily removed by washing. When moisture is wiped off, plug can be used immediately. Water cannot penetrate to wiring.

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The Hubbellock Explosion-Proof Receptacle and Plug prevent arcing when electrical connections are made or broken in explosive atmospheres. No special wiring is required for installation in new or existing structures.

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Ears Could Replace Prints as Accepted Identification Technic, Research Shows

CHICAGO. — The ear may not replace the fingerprint or footprint as positive identification of the newborn — but it could.

In a two-year study conducted at Cook County Hospital here identification of newborn infants by ear photographs proved more than 95 per cent accurate, the report of the study said.

Ten basic types of ears were identified. Of 285 children who were photographed it was established that "no two ears are identical no matter whether of the same individual or of a same-sex twin," the report concluded.

Of the 285 children, 93 were followed up at quarterly intervals over a period of two years and their ear types analyzed as to stability or changeability.

The study was made by Dr. Charles Fields, project director; Dr. Hugh C. Falls, medical researcher; Manuel Zimberoff, medical photographer, and Lois W. Mednick, anthropologist.

"The advantage of ear identification over fingerprints, for example, is that the ear is immediately recognizable," Mr. Zimberoff said. "You don't have to call a specialist or the F.B.I. to satisfy a mother that she was handed the right baby."

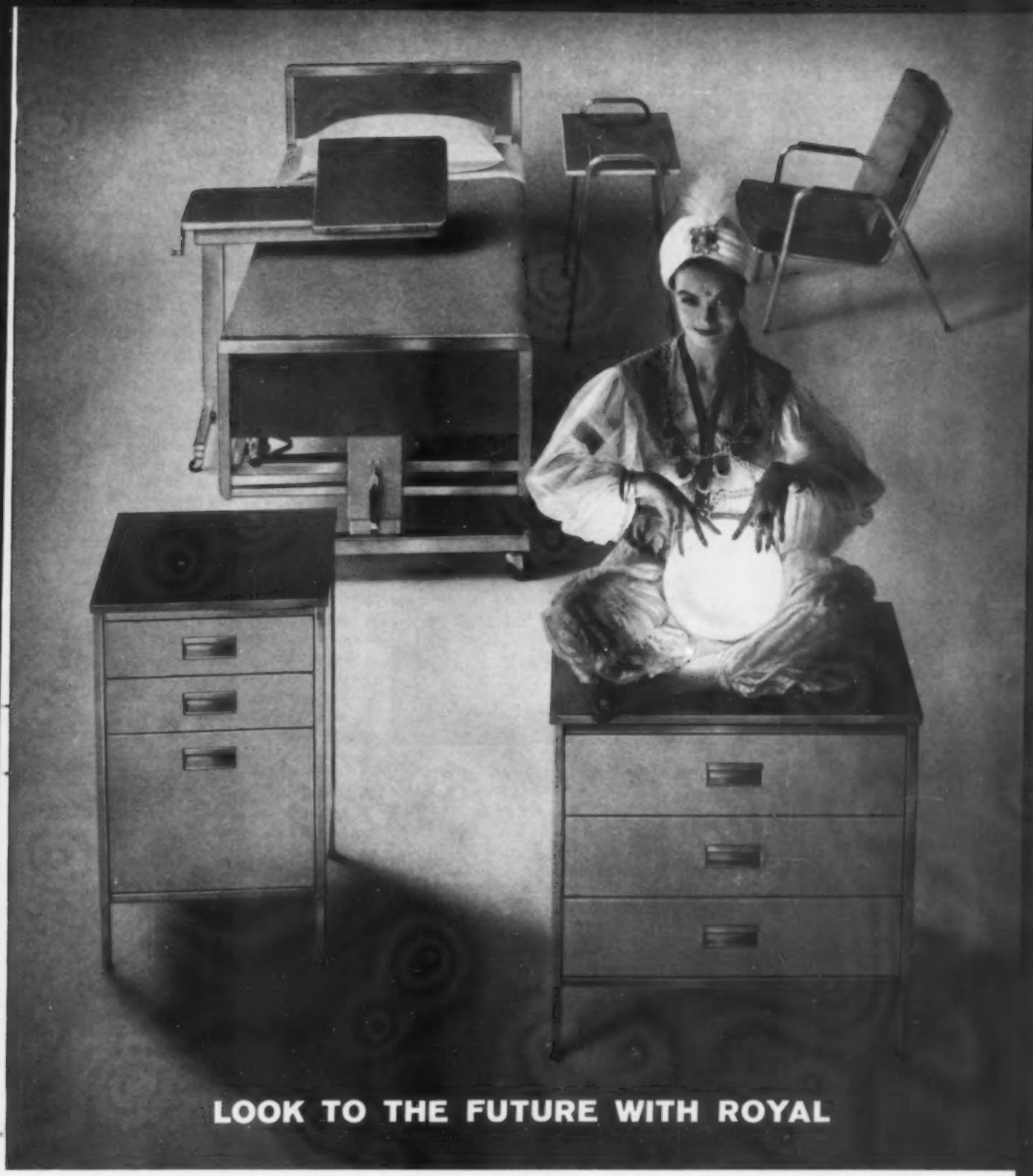
The study also found that in most cases the final ear form could be predicted from first photographs.

Harvard Program Planned for Health Policy Makers

BOSTON. — A training program designed primarily for policy making government officials in the health field has been established at Harvard University.

The five-year program, financed by a federal grant, will explore the economic and administrative coordination of health and medical facilities, it was indicated.

Four of the university's professional schools will be utilized in the program: the school of public health, the graduate school of public administration, the graduate school of business administration, and the medical school. Project director will be Dr. Robert R. Hamlin, associate professor of public health administration.



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N.Y. Legislators Told Blue Cross Salaries Are Strictly in Line

ALBANY, N.Y. — Salaries of Blue Cross employes here "are strictly in line" with comparable salaries in private industry, J. Douglas Colman testified here last month.

Mr. Colman, president of Associated Hospital Service of New York (Blue Cross), spoke at a hearing conducted by the Joint Legislative Committee on Health Insurance Plans of the state legislature.

A 1958 study of executive compensation in the life insurance industry, he said, shows that the industry's compensation for executives was about 80 per cent higher in companies of the size of the New York Blue Cross Plan.

A summary statement accompanying Mr. Colman's testimony described newspaper stories critical of so-called Blue Cross Christmas bonuses as "an attempt to achieve sensationalism." During December, it was explained, employes receive a lump-sum payment based on their base salary and their length of service. This equals 1 per cent of base salary for each year of service, but does not exceed 10 per cent of base salary or $500, whichever is lower.

The program "has helped to retain the services of well trained responsible employes and reduced costly employe turnover," the statement indicated.

Kellogg Grant Enables Minnesota To Start Advanced Education Plan

MINNEAPOLIS. — An advanced center for education beyond the master's degree level in hospital administration is being established at the University of Minnesota.

The center will be financed by a four-year grant of $159,000 from the W. K. Kellogg Foundation, which has sponsored similar programs at the universities of Chicago and Michigan and Columbia University.

The Minnesota center will offer a doctoral degree and will "sponsor basic and applied research, varied continuing education programs, community service projects and the formal preparation of research and teaching personnel," the foundation announced.

Michael Reese Hospital Announces $16 Million Expansion Program

CHICAGO. – A $16 million, five-way expansion program announced by Michael Reese Hospital and Medical Center here last month is only the initial phase of a long-range program that will ultimately bring the capital value of the center to more than $36 million, hospital officials announced at a press conference which included aerial and ground tours of the area.

The five areas that are being developed in the initial phase of the program were outlined by Frank E. Mandel, president, and William J. Silverman, director of Michael Reese, as follows:

1. Research. Ground-breaking will take place this spring for a new research building, which is the second phase of a three-stage laboratory building construction program. Another new building – the Pathology Institute – will house laboratories for pathology research previously limited by inadequate space.

2. Women's and Children's. A women's hospital is in the active, preliminary planning stage. Its companion will be a new pediatric hospital. One plan under study at present is to combine these two buildings into one women's and children's hospital. The site, yet to be decided, will be determined by the functional needs of the buildings or building. The buildings will replace the out-of-date maternity and pediatric facilities.

3. Psychiatric. Ground-breaking for a new psychiatry clinic for outpatients will take place by the end of this year. The first floor of the building will be for psychiatry research, the remaining space for outpatient treatment and training of child psychiatrists. The building will be connected by a bridge to the existing inpatient Psychosomatic and Psychiatric Institute.

4. General Medical and Surgical. A new three-story surgical wing and professional services building, now under construction, will be connected to Kaplan Pavilion and will have 18 large operating rooms, plus four rooms for outpatient surgery. In addition, it will have an 18 bed postoperative recovery room.

5. General Services. A new building will house such services as warehouse building, receiving and shipping docks, housekeeping department storage areas, engineering department office, carpentry, plumber, electrical, painting and other shops.

In addition, an area which had been earmarked by the Chicago Land Clearance Commission for a park to serve the needs of the hospital and people living in the community has been purchased by Michael Reese. The park to be on this site will be completed and in use by this summer, it was stated.

Public Health Doctors in New York Form First Bargaining Unit of Its Kind

NEW YORK. – Physicians and dentists of the New York City Department of Health have formed what is described as the first collective bargaining organization of its kind in the United States.

Named the Doctors' Association of the Department of Health, it seeks salary increases, tenure and pension rights for the 1000 public health doctors with the department, according to the *New York Times*.

The organization, in formation for three years, has been certified by the city labor department and has the backing of the health department.

The American Medical Association's position was termed "neutral" by the *Times*. The bargaining group will not have official backing from the A.M.A. because it does not refer to medical practices, but it is not disapproved as the medical association does not interfere in organizations for salaried persons, according to Dr. Robert M. Robbins, president of the new group.

Dr. Spelman Named Head of Kansas City Association

KANSAS CITY, MO. – Dr. Arch E. Spelman, Smithville, Mo., was elected president of the Kansas City Area Hospital Association by the board of directors following the association's annual meeting.

New chairman of the board is James D. Marshall. He succeeds Maurice Johnson. Other officers elected were: vice presidents, Tom J. Daly and Thomas M. Johnson; secretary, Russell H. Miller, and treasurer, David T. Beals.

Consolidation of 10 Jewish Hospitals Into New York Medical Centers Proposed

NEW YORK. — Consolidation of 10 Jewish hospitals here into coordinated hospital centers has been recommended in a report published last month.

The hospitals are members of the Federation of Jewish Philanthropies of New York, which sponsored the study report, "Planning for Better Hospital Care," published by Columbia University Press.

The report recommended that the Federation's member hospitals here be consolidated into hospital centers, in affiliation with medical schools, in order to provide improved hospital care along with expanded teaching and research facilities.

Specifically it recommended:

— Establishment of a Bronx Jewish Hospital Center by affiliating three Federation general hospitals in the borough — Lebanon, Bronx and Montefiore — in conjunction with Albert Einstein College of Medicine.

— Association of Long Island Jewish Hospital, Hillside Hospital, and the Home and Hospital of the Daughters of Israel into a Jewish Hospital Center of Long Island, in cooperation with one or more medical schools in the metropolitan area.

— Establishment of a joint planning committee of trustees of Brooklyn Jewish and Maimonides hospitals to consider the development of a Jewish Hospital Center in Brooklyn.

— Determination of the possibility of developing closer affiliation for Mount Sinai, Joint Diseases, and Beth Israel hospitals, all in Manhattan, with one or more medical schools. The group also suggested that the Federation determine the feasibility of establishing Joint Diseases Hospital as the orthopedic division of a Federation hospital center.

All of the recommendations in the report have been accepted by the trustees of the Federation.

The report was written by Dr. Eli Ginzberg, professor of economics of Columbia University Graduate School of Business, and Peter Rogatz, M D., associate director of Montefiore Hospital, and previously associate director of the Health Insurance Plan of Greater New York.

Dr. Ginzberg was director of the study by a 17 member subcommittee, established by the Federation to investigate current hospital operations and to develop guidelines for support of the institutions.

24 Maryland Hospitals Form Purchasing Plan

BALTIMORE. — Pooling their purchasing power, 24 Maryland hospitals have formed a group purchase plan that is expected to save patients thousands of dollars.

The first group contract, for x-ray film, was signed February 20 "at a considerable reduction in price," the Hospital Council of Maryland reported.

Group procurement of other items such as fuel oil, surgical dressings, and linens is being studied by the council and it hopes to begin contract negotiations shortly, the council *Newsletter* said.

Initially the savings from the plan are estimated at $15,000, the council reported.

Robert S. Hoyt, administrator of Lutheran Hospital, Baltimore, is chairman of the group purchasing steering committee.

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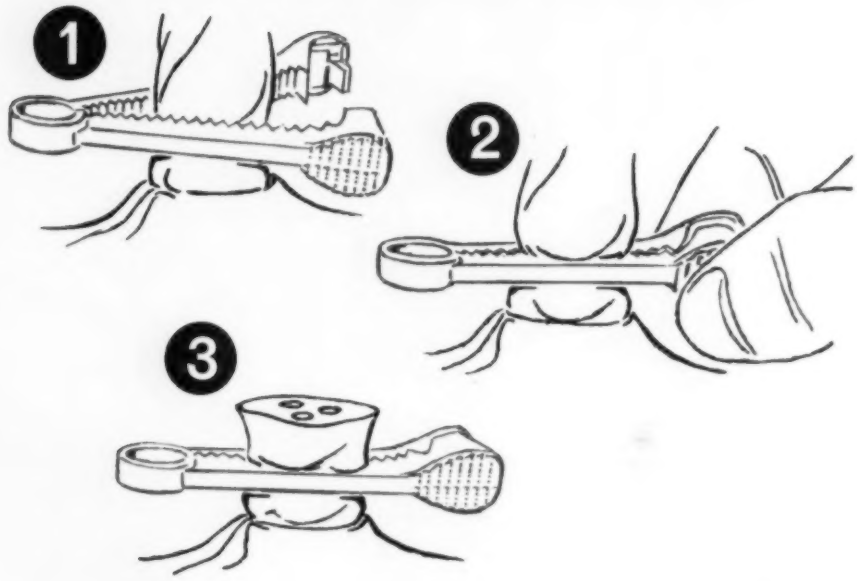

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COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Drake Hotel, Chicago, Oct. 25-28.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convocation, Convention Hall, Atlantic City, Sept. 24.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, Americana Hotel, Bal Harbour, Fla., April 21-28.

AMERICAN COLLEGE OF SURGEONS, Conrad Hilton Hotel, Chicago, Oct. 2-6.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN MEDICAL ASSOCIATION, annual meeting, Coliseum, New York, June 26-30.

AMERICAN PHARMACEUTICAL ASSOCIATION, Hotel Sherman, Chicago, April 23-28.

AMERICAN PUBLIC HEALTH ASSOCIATION, Cobo Hall, Detroit, Nov. 13-17.

AMERICAN SOCIETY OF HOSPITAL PHARMACISTS, Hotel Sherman, Chicago, April 23-28.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May 29-31.

ASSOCIATION OF UNIVERSITY PROGRAMS IN HOSPITAL ADMINISTRATION, Brooke Army Medical Center, Fort Sam Houston, San Antonio, Tex., May 4, 5.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 24-27.

CATHOLIC HOSPITAL ASSOCIATION, Civic Auditorium, Detroit, June 12-15.

COLLEGE OF AMERICAN PATHOLOGISTS, Seattle, October 1-7.

CONNECTICUT HOSPITAL ASSOCIATION, Berlin, June 14.

COMITE DES HOPITAUX DU QUEBEC, Montreal Show Mart Inc., Montreal, Que., June 26-28.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Atlantic City, May 17-19.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Penn Harris Hotel, Harrisburg, Oct. 17, 18.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 10.

IDAHO HOSPITAL ASSOCIATION, Elks Lodge, Boise, Oct. 16, 17.

INTERNATIONAL COLLEGE OF SURGEONS, North American Federation, annual congress, Chicago, May 7-11.

INTERNATIONAL HOSPITAL FEDERATION, Venice, Italy, June 5-9.

IOWA HOSPITAL ASSOCIATION, Fort Des Moines Hotel, Des Moines, April 26, 27.

MAINE HOSPITAL ASSOCIATION, Samoset Hotel, Rockland, June 6, 7.

MARYLAND-D.C. HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, Nov. 8-10.

MASSACHUSETTS HOSPITAL ASSOCIATION, Statler Hilton, Boston, May 11.

MICHIGAN HOSPITAL ASSOCIATION, Hotel Pantlind, Grand Rapids, June 18-20.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 17-19.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 26-28.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, July 12-14.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION AND SERVICE, Statler-Hilton Hotel, Detroit, April 24-28.

NEW HAMPSHIRE HOSPITAL ASSOCIATION, Wentworth-by-the-Sea, Newcastle, June 1, 2.

NEW MEXICO HOSPITAL ASSOCIATION, Albuquerque, May 17-19.

NORTH CAROLINA HOSPITAL ASSOCIATION, Grove Park Inn, Asheville, June 21-23.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 2, 3.

QUEBEC HOSPITAL ASSOCIATION, Queen Elizabeth Hotel, Montreal, April 19-21.

SOUTH DAKOTA ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Spring Institute, St. Mary's Hospital, Pierre, April 28.

SOUTHEASTERN HOSPITAL CONFERENCE, Memphis, April 19-21.

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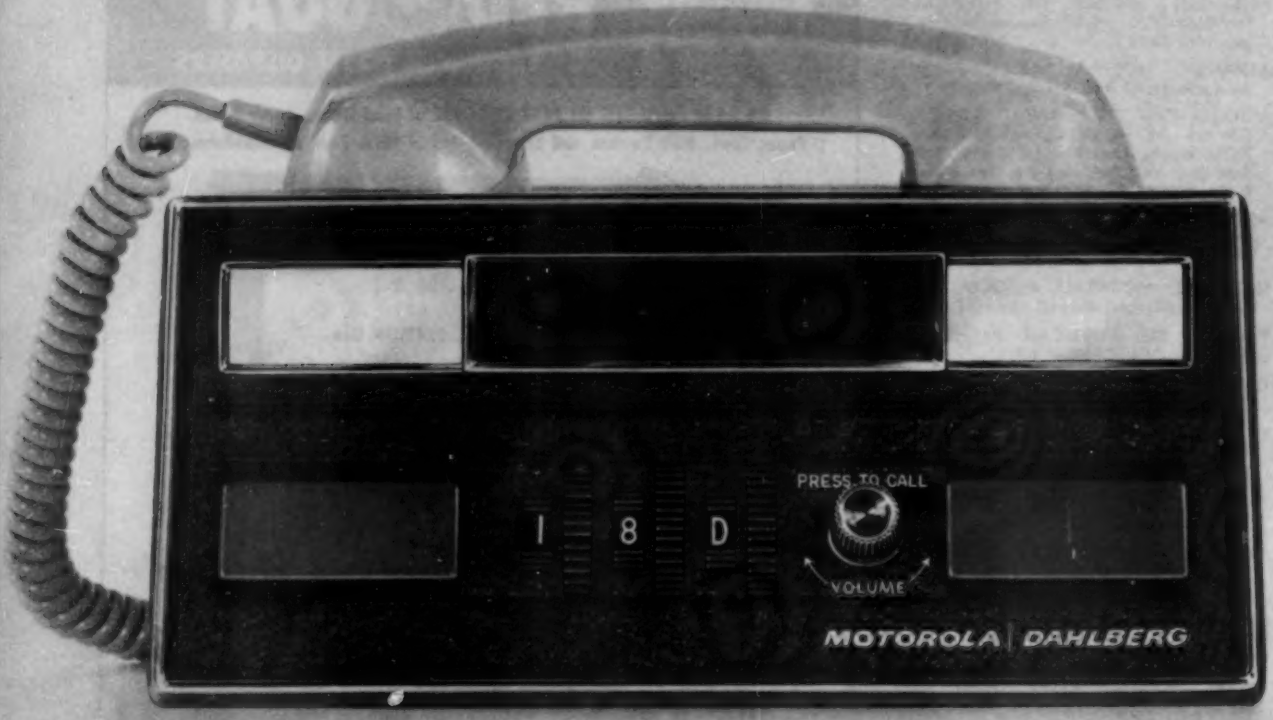

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BRARIANS, Ellis Auditorium, Memphis, April 19-21.

TENNESSEE HOSPITAL ASSOCIATION, Riverside Hotel, Gatlinburg, May 25, 26.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton, Dallas, May 14-17.

THIRD WORLD CONGRESS OF PSYCHIATRY, Montreal, Que., June 4-10.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

UPPER MIDWEST HOSPITAL CONFERENCE, St. Paul, May 10-12.

College of Surgeons Hears Reports on Intensive Care

(*Continued From Page* 88)

sive care unit by a committee representing administration, nursing and medical departments was recommended. At Bryn Mawr, the committee meets monthly to discuss problems encountered in intensive care, Doris Dare, head nurse of the unit there, told the group.

"Examples of problems which have been discussed by the committee are visiting regulations, difficulties in transferring patients, and telephone calls requesting information," Miss Dare said. "Through this committee we have been able to improve communication between the staff doctors, the nursing staff, and the public."

At Albert Einstein Medical Center, 41 out of 850 beds are in the intensive care unit, Dr. Lucchesi reported.

"It has been difficult to determine the cost of intensive care," he said. "Although we are aware that the cost is higher in this unit than in other parts of the hospital, due chiefly to higher concentration of nurses (6.1 hours per patient to 3.3 hours in other nursing units), we have elected to charge the same rate as for other semiprivate areas of the hospital."

Reporting for Jefferson Medical College Hospital, Philadelphia, Evelyn R. Curran, administrative supervisor, said an additional $10 a day was charged to defray the cost of the intensive nursing care.

At Jefferson, Miss Curran said, either the senior surgical or senior medical resident may admit patients to the unit. "In event the disposition of a request is in dispute, the attending chief of anesthesiology or his designated representative will make the final decision," she said.

Terminal cases are not ordinarily admitted to intensive care units, it was reported in the discussion.

Florida Teaching Hospital Stops Accepting Indigents Because of Budget Deficit

GAINESVILLE, FLA. — Indigents are no longer being accepted at the University of Florida's teaching hospital unless they are emergency cases because of an operating deficit that has forced closing of 150 of the hospital's 400 beds.

Officials of the J. Hillis Miller Health Center cited a cut in its proposed budget by the legislature and the lack of paying patients when the hospital first opened in 1958 as major reasons for the deficit, according to the *Tampa Tribune*, which disclosed that the hospital had far exceeded its budget allowance for the current biennium.

The freeze on indigent patients was made for two reasons: to bring more income to the hospital and to provide space for critically ill paying patients who are referred to the hospital, according to Dr. Russell S. Poor, provost of the center.

L. R. Jordan, administrator of the hospital, said he hopes to be able to open 50 more beds by July, provided the legislature authorizes the needed funds. All that is needed to open additional patient space is personnel, the *Tribune* reported.

Mr. Jordan said at present the hospital is staffed for about 60 per cent occupancy, although it has been operating at between 70 and 75 per cent occupancy.

U.C.L.A. Initiates Two Public Health Programs

LOS ANGELES. — Two degrees in public health are being offered this year for the first time at the University of California at Los Angeles. The programs are given by the newly accredited School of Public Health at the university.

Two types of graduate students are accepted, explained Dr. Paul A. Lembcke, director of the program.

Holders of doctorates in medicine, osteopathy, dentistry and other fields related to the healing sciences, and other individuals who may be specially qualified, may enter the program leading to the master of public health degree. Students holding bachelor's degrees are carried in the program leading to the degree of master of science in public health (hospital administration).

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More Than Half of U.S. Deaths Occur in Hospitals; Report Shows Increase

NEW YORK. — The wide use of hospital facilities is reflected in the increasing number of deaths that occur in hospitals, a report from the Metropolitan Life Insurance Company suggests.

More than half of all deaths in the United States — 53 per cent — now occur in hospitals. Twelve years ago, in 1949, this figure was 45 per cent, the report said.

Greater dependence on hospitals by seriously ill persons was suggested as one reason for the rise. "It is expected that an increasing number of people with terminal illnesses will utilize hospital services as the bed capacity and diagnostic and therapeutic facilities of these institutions expand," the report stated.

In a regional breakdown, the report disclosed that the Mountain and Pacific states had the highest rate of deaths occurring in hospitals, 57 per cent. Lowest rate, 43 per cent, was in the East South Central states.

ABOUT PEOPLE

(*Continued From Page* 121)

George W. Warner has been appointed assistant director for special services and **David J. Fanning** has been named assistant director for finance at the University of Rochester Medical Center, Rochester, N.Y. Mr. Warner has been on the administrative staff of the Medical Center since 1955. He formerly was a staff member of the National Cancer Institute, Bethesda, Md. Mr. Fanning has been assistant controller of the university since 1955.

James Henry has been named administrator of Baptist Memorial Hospital, Oklahoma City. Previously, he was administrator of Park View Hospital, El Reno, Okla.

Charles M. Cooper Jr., assistant director of the University of Texas Medical Branch Hospitals, Galveston, was appointed assistant director, Hermann Hospital, Houston.

Elwood R. Eason has been appointed administrative assistant and night administrator at University Hospital and Hillman Clinic, Birmingham, Ala. Mr. Eason did graduate study and his administrative residency at Duke University Medical Center.

Roy R. Creech has been appointed assistant administrator of Cleveland Memorial Hospital, Shelby, N.C. Mr. Creech is a graduate of the Washington University program in hospital administration. He was previously administrative assistant at Memorial Mission Hospital, Asheville, N.C.

Orpha Daly Mohr, former director of purchasing at Chicago Wesley Memorial Hospital, Chicago, is now assistant administrator at Oak Park Hospital, Oak Park, Ill. She holds a bachelor of science degree in hospital administration from Northwestern University.

Richard K. Welch has been appointed assistant administrator of Macon Hospital, Macon, Ga. He completed the course in hospital administration at Georgia State College and has been an administrative assistant at Macon Hospital since 1959.

James L. White is the new associate administrator of St. Joseph-Lloyd Hospital, Menominee, Mich., succeeding **Herbert Rodde,** who is now associate administrator of St. Francis Hospital, Escabana, Mich.

(*Continued on Page* 190)

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- Reception is clear, uniform, static-free. Patients in adjoining beds are free to choose radio or TV programs independently, without interference. Patients who prefer to sleep or read are not bothered.
- Nurse call button—and selector buttons—have durable palladium contacts of special design, for utmost reliability.
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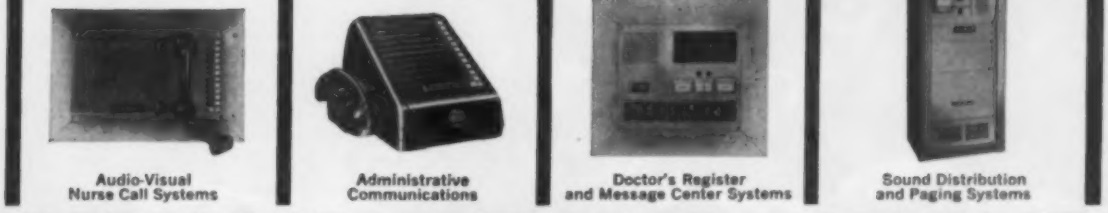

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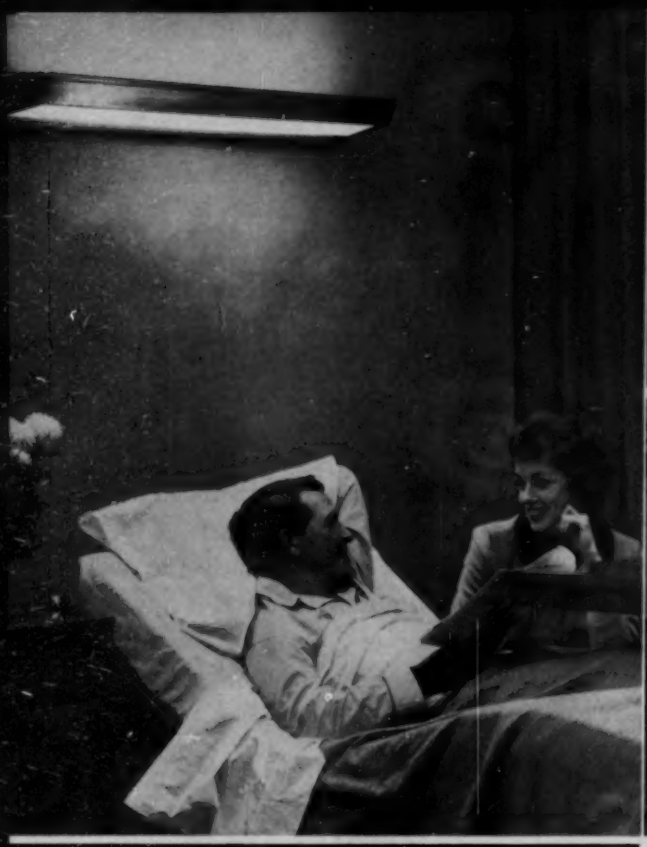

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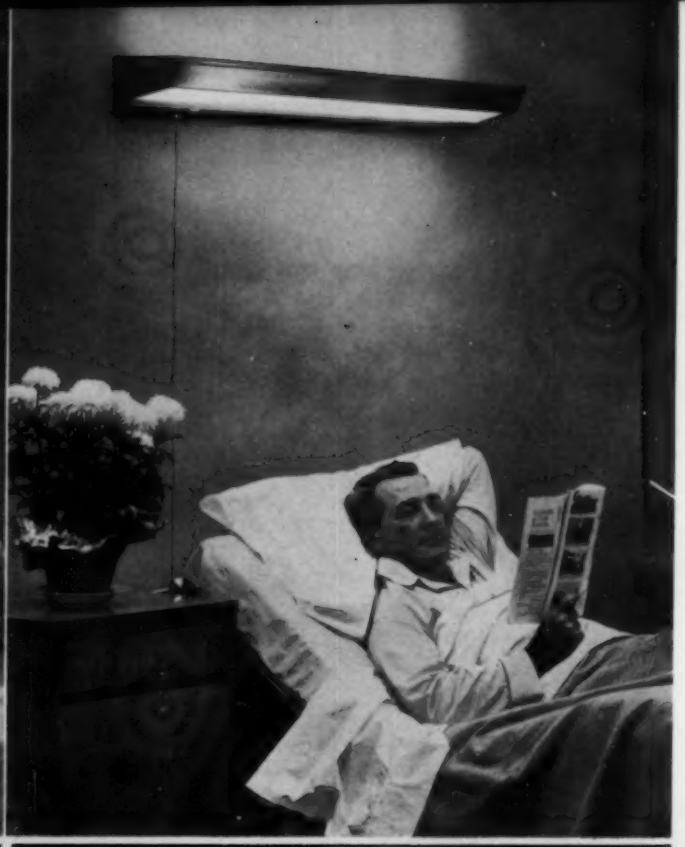

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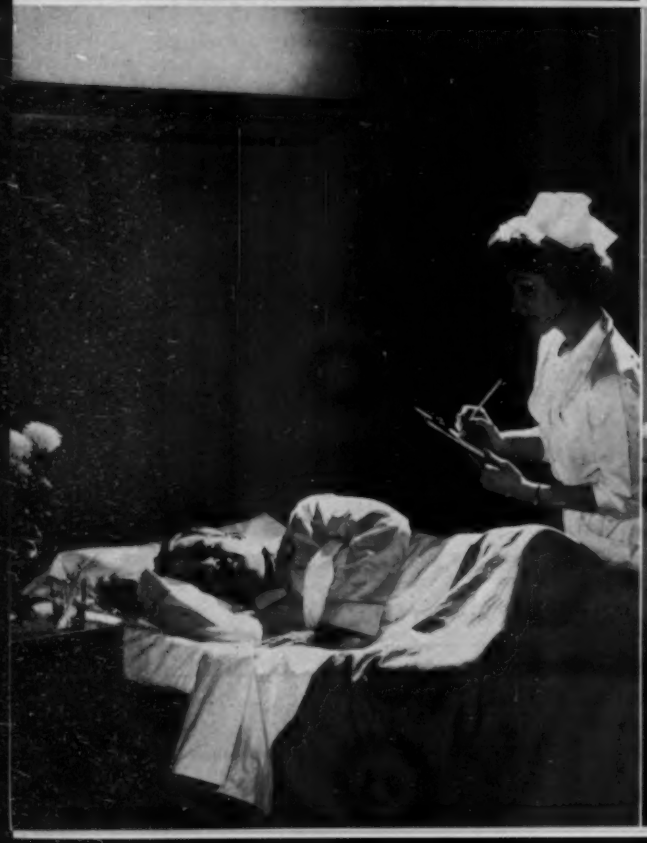

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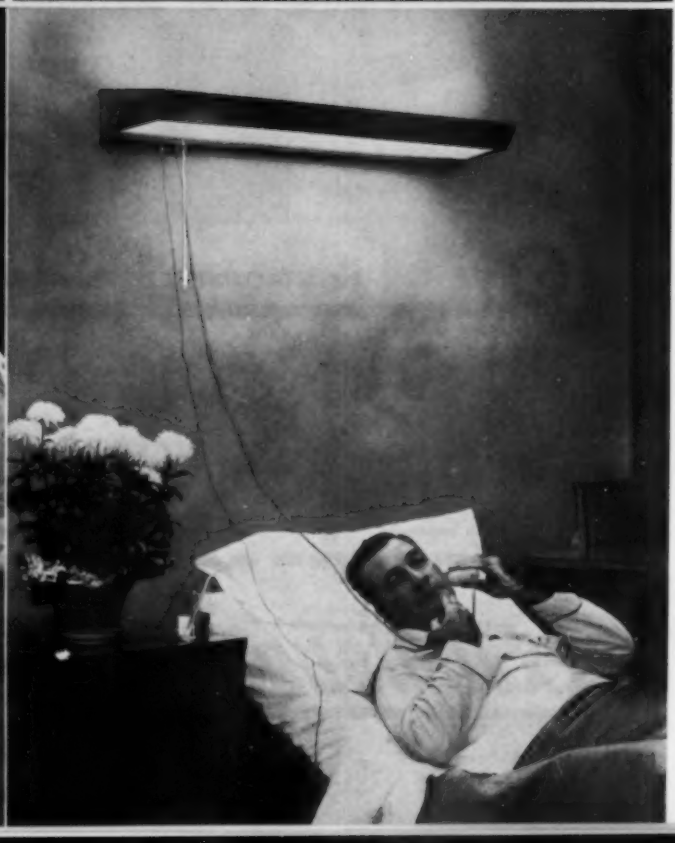

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(*Continued From Page* 186)

Gerald A. Bishop, assistant administrator at Glynn Brunswick Memorial Hospital, Brunswick, Ga., has been named assistant administrator at Carraway Methodist Hospital, Birmingham, Ala.

Ralph B. Clement has been appointed assistant administrator of Genesee County General Hospital Facilities, Flint, Mich.

William C. Hansen, administrator of Mary Secor Hospital, Emmett, Idaho, for the last six years, has resigned to accept the position of administrative assistant and personnel director at St. Alphonsus Hospital, Boise, Idaho.

B. Barton Smythe has been appointed controller of Mound Park and Mercy hospitals, St. Petersburg, Fla.

Lt. Charles F. Johnson has been assigned business officer at the U.S.A.F. hospital, Dow Air Force Base, Me. He recently finished his administrative residency at Menorah Medical Center, Kansas City, Mo., and is a 1960 graduate of the University of Minnesota's program in hospital administration.

John A. Crawford has retired as business manager of Traverse City State Hospital, Traverse City, Mich.

Department Heads

Katharine W. Wells has become director of social services at Mount Sinai Hospital of Greater Miami, Miami Beach. She is a graduate of Northwestern University and took graduate work in social service administration at the University of Chicago.

Yvetta Nelson has been named director of nursing service at White Memorial Hospital, Los Angeles. She received her bachelor's and master's degrees from the College of Medical Evangelists, Los Angeles.

Richard S. Slottow has been named director of development and public relations at Presbyterian-St. Luke's Hospital, Chicago. For the last seven years Mr. Slottow has directed the alumni fund raising and public relations program for Northwestern University.

Marie Pfannenbecker has been named director of nursing service at Flagler Hospital, St. Augustine, Fla. She was formerly a medical-surgical instructor at St. Vincent's Hospital, Jacksonville, Fla.

(*Continued on Page* 192)

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REPORT:
Patient resting comfortably

REASON: Beautyrest

For patients who spend 24 hours a day in bed there is no substitute for *natural* rest. And many hospital authorities agree that, in sleep equipment, there is no substitute for the restful comfort provided by the Beautyrest* mattress—made only by Simmons.

No matter what their weight, patients get uniform body support on Beautyrest. Individually pocketed coils adjust in direct proportion to the pressure put on them. The patient gets the comfort he wants... the firm support his doctor demands.

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(*Continued From Page* 190)

Wayne G. Wascom has been appointed personnel director at Southern Baptist Hospital, New Orleans.

Paul J. Baschon Jr. has been appointed personnel manager and safety director of Winter Haven Hospital, Inc., Winter Haven, Fla.

Miscellaneous

Dr. George A. Wolf Jr., dean of the University of Vermont's college of medicine, has been appointed executive director of Tufts-New England Medical Center, Boston. The appointment will be effective September 1.

Dr. Lawrence G. Christianson, chief of medical service at Fort Meade, S.D., Veterans Administration Hospital, has been appointed assistant director of medical service for the V.A.

Dr. Gilbert H. Mudge has been named associate dean of Johns Hopkins University School of Medicine, with the responsibility of directing and developing the school's postdoctoral programs. In addition to his new duties, Dr. Mudge will continue to serve as professor and chairman of the department of pharmacology and experimental therapeutics.

Sumner G. Whittier, head of the Veterans Administration under President Eisenhower, has been appointed executive director of Michigan Medical Service (Blue Cross).

Jim Reed, editor of the *A.M.A. News,* has taken over the added position of director of press relations of the American Medical Association. He succeeds **John L. Bach,** who has been promoted to assistant director of the department of scientific assembly, a newly created post.

Marie Amadeo Schermer has joined the staff of the Greater New York Hospital Association as public relations assistant.

Deaths

Robert T. Sherman, president of the Blue Cross Plan for Hospital Care of the Hospital Service Corporation, Chicago, died last month. Mr. Sherman had been active in the Blue Cross movement since its founding in 1936. He was a graduate of the Harvard Law School and for many years served as general counsel of the American Hospital Association.

Charles Frederick Neergaard, a pioneer consultant in hospital design, died recently. Mr. Neergaard served as a consultant in the construction of more than 350 hospitals in the United States and 21 foreign countries. In 1921, he organized the first pay clinic in this country. Mr. Neergaard opened his hospital consulting office in New York in 1922 and remained active in the field until 1952, when he retired to devote himself to technical writing for architectural and hospital periodicals.

Msgr. M. F. Griffin, a past president of the Ohio Hospital Association and the Catholic Hospital Association, died recently in Florida.

Dr. S. Howard Armstrong Jr., 48, director of biological sciences and medical education at Cook County Hospital, Chicago, died last month. Dr. Armstrong was considered one of the nation's leading experts on protein metabolism and internal medicine. He was dean of the Cook County Graduate School of Medicine, scientific director of the Hektoen Institute, and a professor of medicine at the University of Illinois.

John Wesley Doubenmier, administrator of Kern County General Hospital, Bakersfield, Calif., died recently. He was a fellow of the American College of Hospital Administrators.

Complete physiologic monitoring facilities

SANBORN "760" EQUIPMENT FOR USE IN SURGERY • CATHETERIZATION • POST-OPERATIVE OBSERVATION • TEACHING

SAFETY and SIMPLICITY are primary characteristics of this new series of monitoring 'scopes, indicators and preamplifiers. Protective networks, current limiting circuitry and low-voltage transistorized preamplifiers are key elements insuring safe operation in the presence of explosive gases. All units are designed for easy, straightforward operation and use—by simple front-panel controls . . . clear, well-defined and well-separated waveform presentation on 17" scope screen . . . orderly, uncluttered interconnection of units, and signal input cables from patient . . . wide mounting flexibility permitting shelf, table, wall, ceiling or mobile cabinet location of units.

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Mr. Clean will clean everything here . . . and practically everything else!

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He's a work-saver, time-saver . . . and really handy to have around! He's Mr. Clean, Procter & Gamble's all-purpose liquid cleaner. Wherever he goes—and that can be almost everywhere—Mr. Clean gets the cleaning job done faster, easier than any other type of cleaning product.

Bathrooms, kitchens, utility rooms . . . why, just a once-over from Mr. Clean and they're spotless and sparkling. For every room and everything washable in the room . . . you'll be really pleased at Mr. Clean's speed.

Used right from the bottle or diluted, Mr. Clean will quickly make light work out of the heaviest cleaning chore. Saves time, too, for many jobs require no rinsing.

And because of Mr. Clean's easy-to-handle bottle, your cleaning personnel can take him along everywhere . . . no need to transfer from large bulky containers . . . no need to guess at amounts. Directions are on every bottle.

Yes, he's the all-time champ at all kinds of cleaning! Meet Mr. Clean himself!

For faster, more efficient cleaning . . . and to keep your maintenance personnel happy

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ADMINISTRATOR—Experienced; college degree and professional registration; age 44; prefers East Coast. Write to MW 99, The MODERN HOSPITAL.

The Medical Bureau
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ASSISTANT ADMINISTRATOR—M.H.A. 10 years experience, 400-bed hospital, wishes administrator, 250-bed hospital, east; 40 years of age.

Recent graduate Hospital Administration Course; 3 years civilian hospital, 15 years military, desires assistant administrator.

PATHOLOGIST—Diplomate; 8 years experience as department division, 300-bed hospital; wishes to locate midwest.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—5 years experience as assistant, 275 bed eastern hospital; charge of purchasing; desires change.

ADMINISTRATOR—Age: 35 years; M.H.A. Degree, mid-western university; 2 years administrative resident, eastern teaching hospital; 5 years assistant administrator; excellent credentials.

ADMINISTRATOR—B.A. Degree; Age: 42 years; administrative resident, 2 years, large Michigan hospital; at present administrator, 80-bed hospital; large out-patient clinic.

COMPTROLLER—Degree in accounting; 4 years assistant controller, 400-bed mid-western hospital.

BUSINESS MANAGER—Or assistant administrator; M.S. Degree; 10 years experience, private and non-profit institutions; any location considered; available.

R.N. ADMINISTRATOR—15 years experience; 110-bed hospital, midwest; outstanding record.

EXECUTIVE HOUSEKEEPER—9 months course, institutional housekeeping; 2 years assistant housekeeper, large eastern hospital; desires change.

POSITIONS OPEN

ANESTHETISTS—Registered Nurse; with operating room experience to work in San Diego County's progressive general hospital; excellent personnel policies; paid holidays, vacation and sick leave; pleasant, mild climate; salary $483-$532; on-call and standby differential. Write COUNTY PERSONNEL DEPARTMENT, 403 Civic Center, San Diego 1, California.

ANESTHETIST—Nurse; for 604-bed general hospital, no pediatric department, 40 hour week, plus overtime, salary open, generous employee benefits. Apply Personnel Office, AKRON CITY HOSPITAL, 525 East Market Street, Akron 9, Ohio.

ANESTHETIST—Nurse; $500; new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

ANESTHETIST—Registered; male or female, fully accredited modern 150-bed hospital, department directed by chief of surgery; starting salary $600 plus 2 weeks vacation, health insurance, sick leave, social security and group life insurance, paid educational leave. Apply to Homer E. Allen, Administrator, CLINCH VALLEY CLINIC HOSPITAL, Richlands, Virginia.

CLINIC COORDINATOR—New outpatient clinic of Cleveland Metropolitan General Hospital has opening for a clinic coordinator with bachelor's degree and five (5) years administrative experience in the health field, preferably in a clinic; to coordinate activities of large, growing outpatient department for medically indigent of teaching hospital, affiliated with Western Reserve University; salary based on qualifications. Apply, Director, CLEVELAND METROPOLITAN GENERAL HOSPITAL, Cleveland 9, Ohio.

DIETITIAN-MANAGER—female; for complete food services; excellent opportunity for ADA registered, mature person, hospital trained, supervisory experience, pleasing personality; position being created by opening August 1, 1961 new modern 223 unit—275 persons retirement community for elderly including on-site 40-bed medical service unit; last word kitchen layout, equipment; location beautiful Pomona-Claremont, California (in Los Angeles metropolitan area); salary open, with private newly furnished staff building apartment if desired, other benefits; submit complete resume, reference; salary desired, date available, to Raymond A. Voigt, Administrator, CONGREGATIONAL HOMES, 366 West Fourth Street, Claremont, California.

DIETITIAN—Excellent opportunity for ADA registered dietitian planning modified diets, writing modified menus, selecting and training employees and directing work of dietary supervisors; 500-bed hospital with 180 dietary employees; salary commensurate with training and experience; liberal benefits. Reply Personnel Director, IOWA METHODIST HOSPITAL, Des Moines 14, Iowa.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries being at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply Director of Dietetics, BARNES HOSPITAL, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Or food service manager; for 90-bed general hospital; liberal vacation, hospitalization, sick allowances; salary open; Contact Emil Wieland, Administrator, JAMESTOWN HOSPITAL, Jamestown, North Dakota.

DIETITIANS—Staff or therapeutic; ADA approved; needed at once; approved, private, non-profit, 604-bed general hospital; good employee benefits; laundry service and meals; salary open. Apply to Mrs. Alice Beech, Personnel Director, AKRON CITY HOSPITAL, 525 E. Market Street, Akron, Ohio.

DIETITIAN—Therapeutic; salary range over $5,000.00; 3 weeks paid vacation; possible advancement to assistant director of department soon; fully accredited 503-bed general hospital (teaching center—300 students.) Apply Director of Dietetics, AULTMAN HOSPITAL, Canton 10, Ohio.

DIETITIAN—Chief; A.D.A.; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 weeks vacation; social security; Blue Cross and Blue Shield available. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—Therapeutic; 500-bed hospital. Apply to Miss Helen M. Druley, Director of Food Service, HARRISBURG POLYCLINIC HOSPITAL, Harrisburg, Pennsylvania.

DIETITIANS—Female; (a) for therapeutic; (b) for main kitchen food production; must be A.D.A. and prefer experienced; 300-bed hospital, adjacent to University of Pittsburgh; housing facilities available, excellent personnel policies; salary open. Write MONTEFIORE HOSPITAL, 3459 Fifth Avenue, Pittsburgh 13, Pennsylvania.

DIETITIANS—Positions open in two of the larger hospitals within a network of ten general hospitals operating in the Appalachian coal mining region of Kentucky, Virginia, and West Virginia; ADA membership required, with experience in administration, teaching, and/or therapeutics; 40 hour week, 4 weeks paid vacation, 7 paid holidays; Employee Health Program; Social Security, plus non-contributory retirement plan; salary open. Write or call collect: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, Williamson, West Virginia. Phone: BELmont 5-2424, Ext. 24.

DIRECTOR OF NURSING—Modern general hospital, 202-beds; excellent equipment and facilities; JCAH accredited; community 14,000; 19 miles west of Sacramento, 85 miles north of San Francisco; salary commensurate with training and experience. Apply W. J. Blevins, Jr., M.D., Medical Director, YOLO GENERAL HOSPITAL, Woodland, California.

DIRECTOR OF NURSING EDUCATION—New school and residence facilities in planning stage; small school, good salary, colleges, nice little city. ASBURY HOSPITAL, Salina, Kansas.

SUPERVISOR OF NURSES—Position open for experienced supervisor of nurses; able to take full responsibility of all phases of nursing for a new 47-bed general hospital A-1 rating; salary open based on experience, education etc.; resort area near Yellowstone National

(Continued on page 196)

classified advertising

POSITIONS OPEN

Park, Wyoming. Apply Administrator, ST. JOHN'S HOSPITAL, P. O. 459, Jackson, Wyoming.

INSTRUCTOR—Clinical in tuberculosis nursing; to supervise students in the clinical areas, teach several hours each week, in a 4 week program in tuberculosis nursing; B.S. in nursing or nursing education required; good personnel policies. Call or write Virginia Ann Smith, Director, School of Affiliation, MUNICIPAL TUBERCULOSIS SANITARIUM, 5601 N. Pulaski Road, Chicago 46, Illinois.

INSTRUCTOR—Medical & surgical; Degree in Nursing or Nursing Education, 150-bed hospital, modern; Central Pennsylvania; $4800 to start; send background information. CLEARFIELD HOSPITAL, Turnpike Avenue, Clearfield, Pennsylvania.

LIBRARIAN—Medical record; chief and assistant; unusual opportunity in midwest; well staffed department in a modern and progressively managed hospital organization; a real challenge for an above average person; exceptional benefits; three and four weeks vacation, extensive sick leave privileges, paid hospitalization, salary wide open; we will pay interview expenses and reimburse person hired a portion of moving expenses. Write to MO 335, The MODERN HOSPITAL.

LIBRARIAN — Medical records; registered for expanded 116-bed hospital; opportunity to reorganize and operate department; original building only six years old, within one hour of New York City; liberal personnel policies; salary open. Write to MO 337, The MODERN HOSPITAL.

LIBRARIANS—Qualified registered medical record; would you like to work in a progressive general hospital and to live in a pleasant, mild climate? two opportunities are available now at San Diego County Hospital; excellent personnel policies include paid holidays, vacation and sick leave; salary $417-$460. Write COUNTY PERSONNEL DEPARTMENT, 403 Civic Center, San Diego 1, California.

LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

NURSES—Registered; staff positions available for new 46-bed general hospital in San Francisco Bay area, opening October 1, 1961; beginning salary $340, differentials for obstetrics, operating room, etc.; fringe benefits include health insurance, vacation, paid holidays and sick leave. Write Administrator, VALLEY MEMORIAL HOSPITAL, P. O. Box 889, Livermore, California.

NURSING LEADER—To replace retiring director June 1st; 100-bed J.C.A.H. accredited hospital; M.D. residency and L.V.N. training programs; join the administrator, medical director, director of nursing as decision making team; reliable supervisors, private secretary, sound personnel policies, good equipment; nearby college resources; 4½ hours to San Francisco or Los Angeles, beach or high Sierras as recreation 1½ hours; 40 hour week, ten holidays, 15 days vacation, sick leave and retirement plan; salary $6,500-$8,000; prefer director with degree who can express needs of nursing service and one who believes in in-service training. Apply Director of Nursing Service, TULARE COUNTY HOSPITAL, Tulare, California.

NURSES—Registered; for general staff and operating room; 202-bed JCAH accredited general hospital; many inviting fringe benefits; to complement present excellent staff situated 19 miles west of Sacramento, 85 miles north of San Francisco, 10 miles from University of California at Davis. Apply Herbert Bauer, M.D., Medical Director, YOLO GENERAL HOSPITAL, Woodland, California.

NURSES—General duty; for 320-bed JCAH accredited general hospital, only a few blocks from Lake Michigan beach and Lincoln Park; near Chicago Loop; school of nursing accredited by NLN; apartments available close to hospital; liberal personnel policies; openings on all shifts; must be eligible for Illinois registration. Write Director of Nursing, AUGUSTANA HOSPITAL, 411 W. Dickens Avenue, Chicago 14, Illinois.

NURSES—General duty; for a 937-bed Medical Center which is expanding dynamically; planning includes facilities for all clinical areas; there is opportunity for promotion in all areas; beginning salary $390 per month; there are differentials for evening tour of duty $40, for night $30; a month's paid vacation annually and other liberal personnel policies; NLN Accredited School of Nursing; there is a nursing service organization in force. Write to the Director of Nursing, MICHAEL REESE HOSPITAL AND MEDICAL CENTER, 29th and Ellis Avenue, Chicago 16, Illinois.

(Continued on page 198)

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Now with 3M's new spray method and "SCOTCH-BRITE" Floor Maintenance Pads you can keep floors new looking week after week after week. This new spray method lets you clean and polish floors in one simple operation. Your floors are kept at a higher level of appearance with less strippings.

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NURSES—Registered and licensed practical nurses; positions open on all shifts; 3:00 P.M. to 11:00 P.M. mostly in need; 272-bed general hospital; new addition recently completed; entire hospital equipped with latest and modern facilities; centrally located in suburbs of Morris County, State of New Jersey, approximately 36 miles from New York City; nurses residence; private rooms nicely furnished; salaries and nurses' personnel policies equal or better than average throughout the state; if interested please write, giving full information and whether or not you are interested in receiving a set of policies; arrangements can be made for interview convenient to applicant. Write Personnel Director, DOVER GENERAL HOSPITAL, Jardine Street, Dover, New Jersey.

NURSES—Staff; for young residential facility for epileptic children with adjustment problems; required: R.N.; interest in therapy, research, and professional training programs; start at $4000 or higher. Write Personnel, NATIONAL CHILDREN'S REHABILITATION CENTER, Leesburg, Virginia.

NURSES—Registered; labor room; general staff duty; all shifts; 3-11 and 11-7 supervisor. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

SOCIAL WORKER—Medical; Challenging; a modern midwest hospital is creating a social service department and needs an above average person to head the department; excellent salary and benefit program; an extraordinary opportunity; will be compensated for interviewing expenses and person hired will be reimbursed a portion of moving expenses. Write to MO 336, The MODERN HOSPITAL.

SOCIAL WORKER—Medical for 300-bed state chronic disease hospital; civil service position with salary range $171.01-$250.-57 bi-weekly; many fringe benefits. Superintendent, CEDARCREST HOSPITAL, Newington, Connecticut.

SUPERVISOR—New 47-bed A-1 rating general hospital in famous Jackson Hole and Yellowstone Park Area; salary commensurated with qualifications and experience. Write to MO 332, The MODERN HOSPITAL.

TECHNOLOGISTS—Medical; ASCP registered or eligible; also, senior technicians with two to three years experience for hematology, blood bank, or pathology of teaching and research hospital in Chicago's Medical Center; University of Illinois affiliation; top salaries for 40 hour week; three weeks vacation and many benefits. Apply Personnel Department, PRESBYTERIAN ST. LUKE'S HOSPITAL, 1753 West Congress Parkway, Chicago 12, Illinois.

TECHNICIAN—Laboratory; in beautiful new expanding hospital located in progressive and interesting city, in smog free resort area; one hour drive from Los Angeles; beginning salary $500 per month, plus liberal fringe benefits. Write Administrator, ANTELOPE VALLEY HOSPITAL, Lancaster, California.

classified advertising

POSITIONS OPEN

TECHNICIAN—Laboratory X-ray; female; experienced for new 47-bed general hospital; salary open; famous Jackson Hole area and Yellowstone National Park. Apply Administrator, ST. JOHN'S HOSPITAL, P. O. 459, Jackson, Wyoming.

The Medical Bureau

M. BURNICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS — (a) Administrator; 100-bed hospital, San Francisco Bay area; executive board of trustees; top salary. (b) Administrator; 50-bed hospital, northern California. (c) Administrator; recent 75-bed hospital, Maine; business accounting background required. (d) Administrator to construct 30-bed hospital Indiana $7,500. (e) Administrator-X-ray combination; 40-bed hospital, Wisconsin, excellent opportunity; also Minnesota. (f) Assistant administrator; new 265-bed hospital near Chicago; initiative will be rewarded. (g) Assistant administrator; large private Florida coast hospital; must have personnel experience. (h) Executive director; 270-bed geriatrics institution near New York City. MH 4-1

ADMINISTRATIVE PERSONNEL — (a) Administrator assistant; knowledge accounting, personnel; rapidly expanding 300-bed hospital suburban Chicago, $6,000 start. (b) Purchasing Agent; 500-bed hospital, midwest; $9,000 up. (c) Personnel director; 350-bed private hospital east; $7,500 up. (d) Controller; 500-bed hospital, university city, Ohio; $10,000 up. (e) Food director; 300-bed hospital near Los Angeles; $8,500. MH 4-2

DIETITIANS—(a) Leading food organization, Philadelphia area; research recipes; consult sales force; some demonstration; assist director; $7,500 start. (b) Chief; 300-bed hospital near D.C.; top salary. MH 4-3

DIRECTORS OF NURSING—(a) Director of Nurses; join administrator and medical director in decision making; 100-bed accredited hospital, High Sierras, California; $8,000. (b) Direct well oriented nursing service 300-bed hospital near Chicago; $8,000. (c) Direct and develop two year nursing program, commuting distance New York City; to $10,000. (d) Direct school, service, 200-bed hospital; Michigan; to $10,000. MH 4-5

EXECUTIVE HOUSEKEEPERS — Brand new 250-bed hospital near Chicago; organize department, excellent financial opportunity. MH 4-6

MEDICAL RECORD LIBRARIANS—Consultant medical record librarian to six hospitals in lake resort area, midwest; $8,500. (b) Chief; ability to set up system, Los Angeles area hospital expanding from 200-400; $6-7,500; MH 4-7

(Continued on page 200)

classified advertising

POSITIONS OPEN

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATORS — (a) 225-bed New England hospital. (b) 80-bed hospital, northeastern resort community. (c) Small western hospital; anesthesia or technician experience. (d) R.N.; 30-bed hospital, Wisconsin.

ADMINISTRATIVE ASSISTANTS — (a) Small midwestern community hospital, planning a 150-bed addition. (b) South central 130-bed hospital; accounting experience. (c) 300-bed western hospital; experience as purchasing agent.

PERSONNEL DIRECTORS—(a) 300-bed hospital, college town, central states. (b) 450-bed hospital, Ohio.

DIRECTORS, SCHOOL OF NURSING—(a) 225-bed hospital, eastern Pennsylvania. (b) Directors, nursing service; to $8,000.

CHIEF ENGINEER—(a) Florida. (b) 200-bed eastern hospital.

CREDIT—Collection officer; (a) 200-bed eastern hospital. (b) Office manager; 225-bed Michigan hospital.

EXECUTIVE HOUSEKEEPERS—(a) 200-bed Sisters' hospital, west. (b) 275-bed Iowa hospital. (c) 150-bed Pennsylvania hospital.

MISCELLANEOUS

OPERATING ROOM SUPERVISOR AND CLINICAL INSTRUCTOR, O. R. Nursing (two positions)

For well-established voluntary 400-bed general hospital with two divisions, each with supervisory assistants and each with a caseload of about 450 operations a month. Seasoned staff of 44 including full-time Clinical Instructor in Operating Room Nursing. Three year diploma program with League accreditation, 100 students. Recovery rooms in each facility.

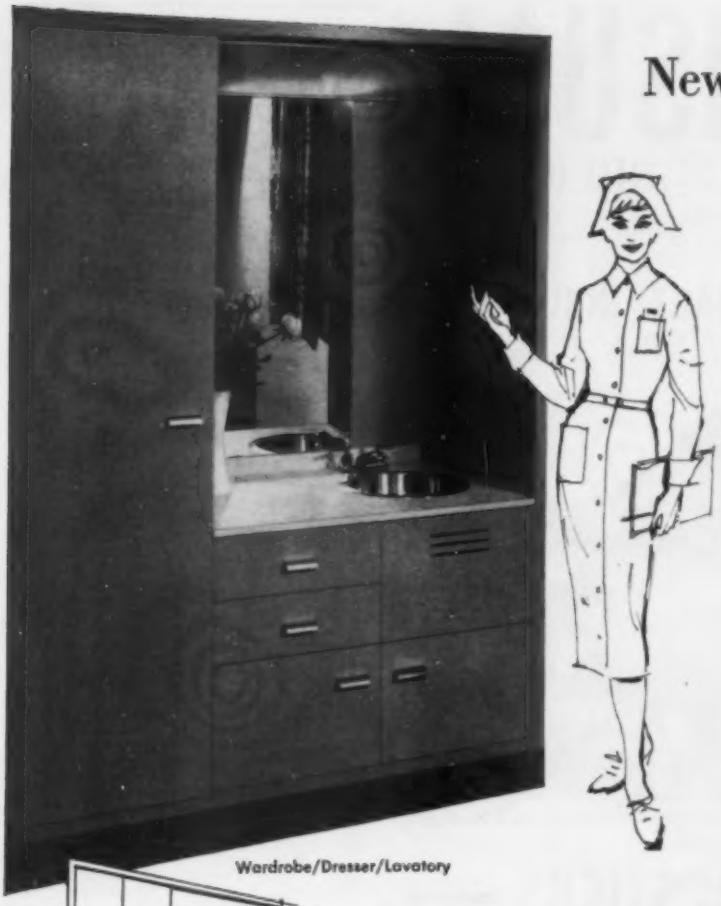
Operating Room Supervisory position requires master's degree, five years of experience in operating room including teaching — supervisory responsibility or B.S. degree with equivalent experience and preferably a post graduate course in operating room nursing. Clinical Instructor, O.R. Nursing requires master's degree, five years of experience in operating room including teaching responsibility or B.S. degree in Nursing Education with experience in teaching operating room nursing.

Registration or eligibility for registration in New York State. Responsible to Director of Nursing and Administrator of Hospital. Well balanced personnel policies include four weeks' vacation, seven paid holidays, two weeks' sick leave and Cumulative sick benefits, pension plan, social security, Blue Cross, group disability and life insurance coverage scaled to salary. Salary dependent upon educational qualifications and experience. Write Director of Nursing, THE ROCHESTER GENERAL HOSPITAL, Northside Division, Rochester 21, New York.

(Continued on page 202)

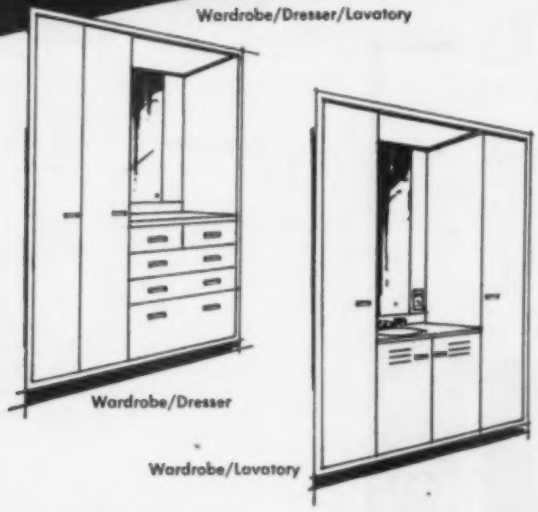
New developments in patient care...

by St. Charles



Wardrobe/Dresser/Lavatory

Medi-Serv Unit



Wardrobe/Dresser

Wardrobe/Lavatory

Nurses Station

"Patient Line" Wardrobes. Functionally designed to meet all storage, vanity and lavatory requirements. An attractive, efficient and economical solution to patient room storage and grooming convenience. Completely flexible . . . built-in or free-standing . . . meets varying patient room needs in new plans or alterations of existing buildings.

Nurses Station. Compact, space-saving "Medi-Serv" Unit includes sink, refrigerator and adequate storage for medicine preparation needs. Custom designed nurses desk includes nurses call unit.

For complete information *and specifications of the complete line of St. Charles casework systems for all hospital storage requirements write, on your letterhead, to:*

St. Charles

Hospital Casework Systems

St. Charles Mfg. Co., Dept. MHH-4, St. Charles, Ill.

classified advertising

PLACEMENT BUREAUS

DOROTHEA BOWLBY ASSOCIATES

A Nation Wide Specialized Employment

Service For Medical and Hospital Personnel

Dorothea Bowlby, Director

Suite 603 Willoughby Tower,

ANdover 3—5293

8 South Michigan Avenue,

Chicago 3, Illinois

Our service is for Men and Women. Administrators, Physicians, Personnel Directors, Business Managers, Purchasing Agents, Comptrollers, Plant Engineers, Public Relations Directors, Pharmacists, Dietitians, Food Service Directors, Physical Therapist, Occupational Therapists, Medical Record Librarians, Librarians, Anesthetists, Director Nurses, etc., Bacteriologists, Biochemists, Microbiologists, Virologists, Tissue Technicians.

ALL INQUIRIES FROM APPLICANTS ARE KEPT STRICTLY CONFIDENTIAL

MARY A. JOHNSON ASSOCIATES

11 West 42 Street .... New York 36, N.Y.

A SELECTIVE PLACEMENT BUREAU FOR MEDICAL AND HOSPITAL PERSONNEL

We welcome inquiries for the many challenging opportunities we have for Administrators, Physicians, Nursing Executives, Medical Record Librarians, Dietitians, Laundry Managers, and all other Medical and Hospital Personnel who wish to relocate.

All negotiations strictly confidential
No registration fee

INDIANA MEDICAL BUREAU

212 Bankers Trust Bldg.
Indianapolis 4, Ind.

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

classified advertising

PLACEMENT BUREAUS

Information about

QUALIFIED NURSE PERSONNEL

is available from the

American Nurses' Association

PROFESSIONAL COUNSELING &

PLACEMENT SERVICE

10 Columbus Circle

New York 19, N. Y.

Tel. Ju 2-7230

FOR SALE

MEMORIAL HOSPITAL, Belleville, Illinois, has the following surplus equipment, all in excellent condition, for sale:

1—Bishop Starch Cooker, Model B3-5 Serial #L1757

1—Bishop Soap Cooking Tank, Model B6 Serial #L1922

1—G. H. Bishop Co. Ironing Board

1—Wilmot-Castle Instrument Sterilizer Type #150, Serial #372576

1—Southern Cross Nipple Washer Model #NW-604

3—American Std. Water Closet NEOLO #HF 13470 VN (Integral Seat)

1—Hobart Potato Peeler, Model #S-12, Serial #3736, 5 lb. capacity

1—Castle Flask Heating Cabinet Model #3000, Serial #381103, 77" high x 29" wide x 29" deep 60 lb. steam — free standing type

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

(Continued on page 204)

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurses Anesthetists. Unlimited opportunities for endotracheal intubations, open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan."

MT. CARMEL MERCY HOSPITAL offers an 18 month course in Anesthesiology to registered nurses of accredited schools of nursing. Approved by American Association of Nurse Anesthetists. Stipend provided. Write for complete details regarding theoretical and clinical teaching and requirements for entrance. School of Anesthesia, MT. CARMEL MERCY HOSPITAL, Detroit 35, Michigan.

UNIVERSITY OF OSLO International Summer School offers course a second time in medical care and public health services in Norway. July 1 to 28. 14 day field trip; two weeks of lectures and local visits in Oslo. Registration limited. Write Admissions Office, OSLO INTERNATIONAL SUMMER SCHOOL, Northfield, Minnesota.

CHARLES T. MILLER HOSPITAL offers qualified graduate nurses a 16 weeks' course in operating room nursing. The course includes instruction and supervised experience in all surgical specialties as well as teaching and management techniques. Room, board, laundry, and a stipend of $125 per month are provided. For information address Director of Nursing, CHARLES T. MILLER HOSPITAL, St. Paul 2, Minn.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition $100.00 approved by the American Medical Association. For further information, write the Director of Laboratories, BARNES HOSPITAL, 600 S. Kingshighway, St. Louis 10, Missouri.

BARNES HOSPITAL—Offers an 18 month post-graduate course on Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director, Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Mo.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, PROVIDENCE LYING-IN HOSPITAL, Providence 8, Rhode Island.

TOO LATE TO CLASSIFY

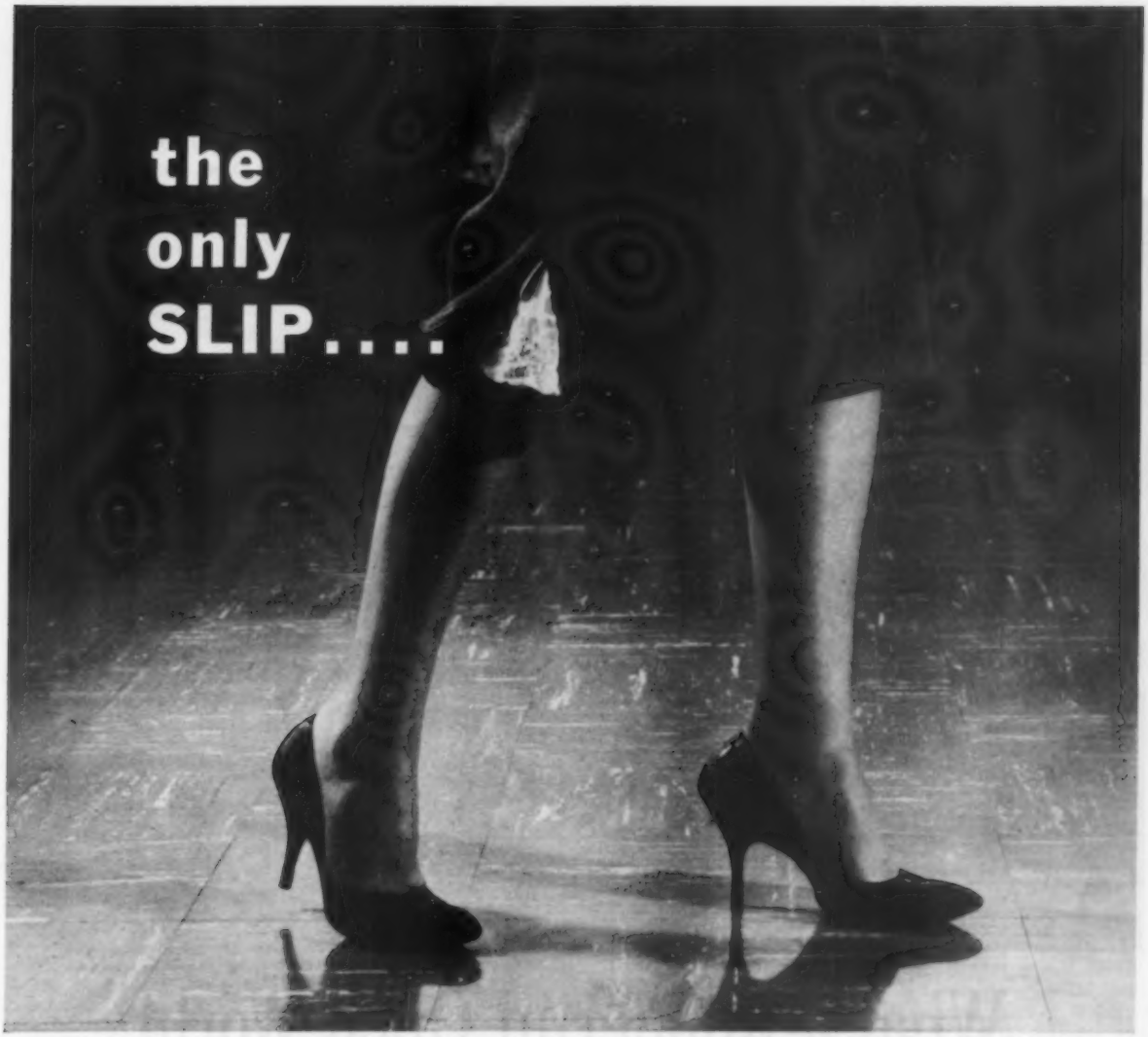
POSITIONS OPEN

DIRECTOR OF NURSING—For a 180-bed hospital located in southern New England; must have Masters Degree and be capable of directing nursing school and service; salary $8,000 up, dependent upon experience; excellent fringe benefits; willing to consider persons with limited experience who have potential; please provide full details in first letter. Write to Box MO 338, The MODERN HOSPITAL.

INSTRUCTOR—Fundamentals of nursing; B.S. degree and teaching experience required; includes both formal and clinical instruction; Diploma Program; remuneration and fringe benefits excellent. Apply The WILLIAM W. BACKUS HOSPITAL, Personnel Department, Norwich, Connecticut.

LIBRARIAN—Registered medical records; challenging opportunity for a fully qualified medical records librarian to take over an active record department presently undergoing complete remodeling and reorganization; salary open, fully accredited 250-bed teaching, non-sectarian community hospital; approved intern resident program and schools of nursing, anesthesia and X-ray technology; $2,000,000 development program underway to provide new surgical suite, intensive care unit, psychiatric section and additional bed capacity. Apply, Personnel Director, RAVENSWOOD HOSPITAL, 1931 Wilson Avenue, Chicago 40, Illinois.

NURSES—California hospital, 241-beds, JCAH accredited, pulmonary (including tuberculosis), general medical and rehabilitation; scenic foothill central California location excellent living arrangements; salaries: staff registered nurse $332 to $415; supervisor registered nurses $371 to $464; experience with good references, eligible California registration. Contact Director of Nurses, TULARE-KINGS COUNTIES HOSPITAL, Springville, California.



...you'll see on a floor protected by Holcomb Anti-Skid Wax!

Slip-resistance is one quality you're always sure of with Holcomb ANTI-SKID WAX.

And you get this "most wanted" feature of safety with no sacrifice in durability and floor beauty.

In fact, Holcomb ANTI-SKID WAX is scientifically designed to bring to your floors a rich, velvety sheen that gives your "housekeeping" a mark of distinction.

Let your Holcombman show you how ANTI-SKID WAX will give your floors *safe beauty* . . . at half your present costs—or even less. For the name of the Holcombman in your community write:

All Holcomb waxes are listed slip resistant by the Underwriters Laboratories.

J. I. HOLCOMB MFG. CO., INC. · 1601 BARTH AVENUE · INDIANAPOLIS, INDIANA
Hackensack · Dallas · Los Angeles · Toronto

Rooms in the old and new wings of Roger Williams General Hospital, Providence, R. I. New wing designed by Howe & Prout, Providence.

What a wonderful Open World© today's patients enjoy

Compare the two rooms above. One is dark and confining. The other, bright and cheerful. Daylight and sunshine lend a healing hand. And patients feel less restless when they can see the open world around them.

The wall-to-wall windows in the new wing of Roger Williams Hospital are glazed with *Thermopane*® insulating glass. Patients get nature's therapy with none of her seasonal discomforts. Rooms stay cooler, despite summer heat; rooms stay warmer, despite winter chill; rooms stay peaceful and quiet, despite the traffic roaring by.

Use Thermopane in hospital windows to save on heating and air-conditioning costs. To control sun heat and glare, specify L·O·F Heat Absorbing plate glass or *Parallel-O-Grey*® plate glass for the outer pane.

For technical information on Thermopane and other L·O·F glass, consult your architect. Or ask your L·O·F Glass Distributor or Dealer (listed under "Glass" in the Yellow Pages).

LIBBEY • OWENS • FORD

TOLEDO 1, OHIO

L O F GLASS

THE QUALITY MARK TO LOOK FOR

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 235. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

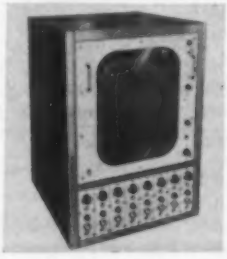
Borg-Warner Motorized Bed Has Touch-Toe Controls

The Touch-Toe Position Selector or the Patient Control Switch operate the new low-cost Borg-Warner fully motorized hospital bed. The Touch-Toe selector unit

is at the foot of the bed with five selectors, each clearly marked for individual bed positions, including Trendelenburg, Knee, Stretcher Level, Back and Reverse Trendelenburg. The patient switch controls movement of the bed to positions pre-set by the nurse with the Touch-Toe control, and the simple two-button up-and-down switch controls the high-low feature. The new bed is the result of study and research among hospital executives and of field tests of pilot models. It is sturdy, simple and easy to maintain, mounted on five-inch casters for easy mobility, has Underwriters Laboratories approval for use with oxygen administering equipment, provides all of the comfort and convenience of full motorization, and is low in initial, maintenance and operational costs. **Ingersoll Products Div., Borg-Warner Corp., 1000 W. 120th St., Chicago 43.**

For more details circle #891 on mailing card.

Monitoring Oscilloscope Displays Up to Eight Waveforms



Simultaneously displaying up to eight waveforms, the new Sanborn 17-inch Monitoring Oscilloscope is specifically designed for use as a visual monitoring instrument with multi-channel oscillographic recording systems. The Model 769 Viso-Scope provides instantaneous presentation of events and supplements the written record of the recording system. The number of amplifiers determines the number of events that may be viewed so that initially, only the desired number of amplifiers need be purchased. Others can be added up to a total of eight. The Model 769 is housed in its own cabinet in which the viewing unit can be tilted so that the entire unit can be located above eye level. **Sanborn Co., Medical Div., 175 Wyman St., Waltham 54, Mass.**

For more details circle #892 on mailing card.

Disposable Soap Dishes Help Prevent Infections

Impervious to soap and moisture, the Chieftain disposable soap dishes cost so little that each patient can be given a fresh, bacteria-free dish. Another block to cross-infection, the dishes can be incinerated after use. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #893 on mailing card.

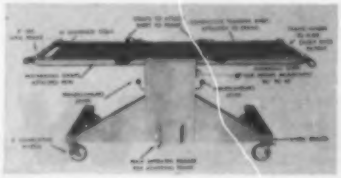
Increased Noise Control in Soundmaster Folding Partition

Sound insulating characteristics equal to those of a solid masonry wall are claimed for the new Soundmaster 240 folding partition. The steel-lined unit has twelve separate layers of material. Two of these are 24-gauge steel measuring 5¾ inches wide and extending the entire partition length on each side of each panel. All four horizontal edges are double insulated and four inner sealer strips of felt combine with four double-coated rubber and fabric seals to lock out sound. Foam rubber is used as an insulator where partitions join. The Soundmaster 240 can be used to partition almost any interior space and is available in single partitions up to 25 feet high by 60 feet wide. Any number of partitions can be installed to accommodate any desired width. **New Castle Products, Inc., New Castle, Ind.**

For more details circle #894 on mailing card.

Improved Patient Handling With Trans-Lift

A new concept in patient handling is offered in Trans-Lift, engineered to fit under and over hospital beds, surgical tables, x-ray machines and the like. It is designed to transfer hospital patients from emergency or other areas, through x-ray, surgery, recovery and to bed without lifting. The patient is placed on a conductive sheet, the Trans-Lift is rolled up, the sheet

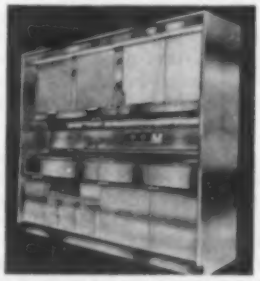


attached to the unit, and the patient lifted by hydraulic power and transferred to any section of the hospital. He need not be taken off the sheet, even for x-ray, as the conductive sheet does not affect the clarity of x-ray pictures. A single nurse, using the Trans-Lift, can raise up to half a ton of weight easily and effortlessly with the hydraulic lift, eliminating the possibility of injury or strain to patient or nurse. **Simmons Co., Hausted Div., Medina, Ohio.**

For more details circle #895 on mailing card.

One-Stop Nourishment-Ice Station Saves Time and Effort

Specifically designed to save nursing time and effort, and to reduce ice contamination hazards, the new One-Stop Nourishment and Ice Station for Hospitals includes complete facilities for the storing, preparing and dispensing of between-meal snacks, prescribed nourishment and ice. All facilities for preparing ice water, hot tea, soup or desserts are supplied in the unit which is only 72 inches wide, 80 inches high and 28 inches deep. Work



counter, storage drawers and cabinets, sink, hot plates, refrigeration and ice-making are all included in the complete, compact station. The automatic ice-maker and dispenser stores the ice in sealed units, ensuring its sanitary condition, and the ice is dispensed directly into container or pitcher by operating a lever. **Market Forge Co., Everett 49, Mass.**

For more details circle #896 on mailing card.

(Continued on page 208)

Coleo Deodorant Soap Contains TCSA Bacteriostat

An anti-bacterial deodorant soap is introduced by Colgate-Palmolive in Coleo. Containing a new bacteriostat called TCSA, the high-quality, gentle toilet soap reduces bacteria and removes offensive odors while cleansing the skin. Coleo lathers freely in hard or soft, hot or cold water, and is supplied in three sizes. **Colgate-Palmolive Co., 300 Park Ave., New York 22.**

For more details circle #897 on mailing card.

Microporous Surgical Tape Is Non-Irritating

Clinical tests show the new "Scotch" brand Microporous Surgical Tape No. 530 to provide almost complete relief from skin irritation. Both backing and adhesive feature countless tiny airways, permitting the skin beneath the tape to function normally and preventing occlusion of the skin, a major cause of irritation. The new tape can be removed painlessly, even after prolonged application, does not cause itching and cannot sweat off. The tape is virtually transparent, permitting observation of wound drainage without removing the surgical dressing. **Minnesota Mining & Mfg. Co., 900 Bush St., St. Paul 6, Minn.**

For more details circle #898 on mailing card.

Curity "Sure Grip" Bottle Shaped to Fit the Hand

Made of rugged shock resistant glass with a concaved middle shaped to fit the hand, the new Curity "Sure Grip" nursing bottle is easier to hold. The new cap and disc design helps maintain sterility by

making it easier to push the nipple through the cap without touching it. The complete nurser unit includes bottle, nipple, cap and disc and is available in eight and four-ounce sizes. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #899 on mailing card.

HOW to Solve Your Housekeeping Problems by pushing a button

Drop that comb and scrape no more Just push a button for the cleanest floor

If your housekeeping staff has been scraping and combing their dry mops, they ought to get acquainted with the Hoffman Sani-Mop Vac System. The Sani-Mop Vac System removes dust and lint from dry mops, dusters, dust cloths, etc., quickly and easily. Come to think of it, once you've familiarized yourself with the Sani-Mop Vac System, you'll wonder how housekeeping personnel got along without it. In fact, many important people have been known to cheer it as a highly significant contribution to health and efficiency.

PUSH BUTTON CLEANING

Now, it doesn't make any difference whether you're responsible for cleanliness in a hospital, dormitory, school, laboratory, hotel, motel, library, apartment house, office building or any other structure with a waxed or polished floor area. If you use dry mops, dusters, dust cloths, etc., you surely can obtain maximum cleaning efficiency and economy with the Sani-Mop Vac System. All it takes to insure ideal housekeeping is the push of a button.

TIGHT PACKAGE

The Sani-Mop Vac System is automatic and compact. Its half-dozen component parts in a really tight package provide these important advantages over conventional methods of dry mop cleaning.

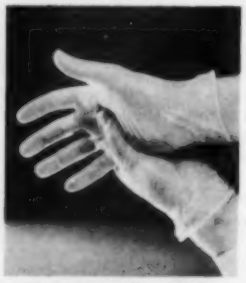
1. Leaves no brush marks on polished floors
2. Can be installed in corridors and closets
3. Protects cleaners against contagion
4. Prevents spread of dirt and germs
5. Entire system requires minimum space
6. Eliminates scraping and combing of mops
7. Can be employed for vacuum cleaning
8. Cloth wrapping of mops is unnecessary
9. Easily installed—requires no maintenance
10. Mops can be treated to give shiny quality to floors
11. Push-button control provides instant cleaning
12. Saves time and labor

WHERE TO GET IT

Without cost or obligation, Hoffman representatives in the U. S. and Canada are available to make recommendations for a push-button solution to your housekeeping problems. Send today for a free brochure. Write Dept. MH, Air Appliance Div., U.S. Hoffman Machinery Corp., 103 Fourth Ave., N. Y. 3.

Wilson Tru-Touch Is Plastic Disposable Glove

Made from a polyvinyl formulation without seams, and offering extraordinary sensitivity with strength enough for any type of digital examination, Wilson Tru-Touch plastic disposable examination gloves are low enough in cost for one-



time use. They fit well, with no constriction of hand and fingers, and save the time of cleaning and resterilizing. **Becton, Dickinson & Co., Rutherford, N. J.**

For more details circle #900 on mailing card.

Deep Fat Frier Has Built-In Baffles

A stainless steel tub with built-in baffles which will not loosen or burn out is featured in the new Hi-Fri deep fat frier introduced by Mer-Kon. High production with a capacity of 60 pounds of raw potatoes per hour is possible with the frying area of 14 square inches. The Hi-Fri is conveniently drained and cleaned from the front and a new Thermi jet burner provides maximum gas efficiency with quiet positive igniting. **Mer-Kon Corp., 9201 King St., Franklin Park, Ill.**

For more details circle #901 on mailing card.

(Continued on page 210)

Rx-HAUGHTON Design and Modernization Services

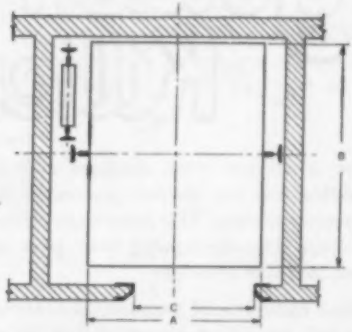
It's no wonder many hospitals have elevator problems. Current standards for hospital elevators specify inside car width of 5′ 4″ and depth of 8′ for elevators rated at 3500 lbs. load capacity. For a 4000 lb. rating, width 5′ 8″ and depth 8′ 4″.

These recommended dimensions and capacities are just not adequate anymore.

Many hospital beds, with attachments are actually over 8½′ in length . . . an impossible "fit" in an 8′ car. And many of the new, improved iron lungs are too big for elevators designed to present standards. You can name other examples of equipment that won't fit into your elevators.

You'll be glad to know that Haughton engineers don't rely on these obsolete standards . . . but recommend equipment for today's needs on all new hospital construction and modernization jobs. This *realistic* approach will best serve the vital elevator needs of *your* hospital . . . and assure elevator service that's an asset, not a handicap.

Your Haughton representative will freely consult with you without cost or obligation, so call him in soon.



HOSPITAL ELEVATOR STANDARDS RECOMMENDED BY HAUGHTON

LOAD	DIMENSIONS		
	A	B	C
4000 lbs.	5′4″	9′0″	4′
4500 lbs.	5′8″	9′6″	4′
5000 lbs.	6′0″	9′6″	4′

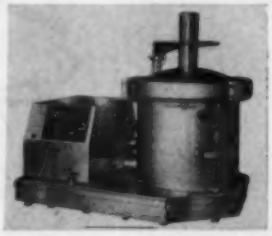
HAUGHTON ELEVATOR COMPANY
DIVISION OF TOLEDO SCALE CORPORATION · TOLEDO 9, OHIO

West Coast Regional Office, Los Angeles 26

FACTORY BRANCHES TO SERVE YOU COAST TO COAST

K-6 and L-6 Hydraxtors Have Increased Capacity

Designed to augment the existing K and L models in the line of hydraulic extractors, the new Models K-6 and L-6 Hydraxtors provide increased capacity of

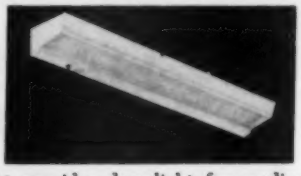


from 20 to 30 per cent. They are intended for use in laundries which have washer pocket loads running from 200 to 240 pounds and both of the new models have an additional depth of six inches. The K-6 features a self-contained recirculation system for water saving, and the L-6 disposes of the water after every load. Both new Hydraxtors have fully automatic operation. **The Hydraxtor Co., 7415 N. St. Louis Ave., Skokie, Ill.**

For more details circle #902 on mailing card.

Hospital Bed Light Has Three-way Lighting

Available in two-foot or four-foot models, the new fluorescent Hospital Bed

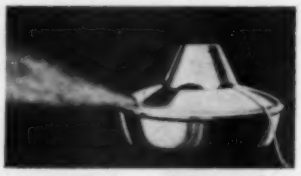


Light provides downlight for reading or examination, uplight for soft general illumination, or both. The fixture is finished in stainless steel or baked white enamel and lighting surfaces are shielded with Day-Brite Cleartex prismatic plastic panels. A convenience outlet is located next to the switch on the bottom of the fixture. **Day-Brite Lighting, Inc., 6260 N. Broadway, St. Louis 15, Mo.**

For more details circle #903 on mailing card.

Thera-Mist Vaporizer-Humidifier Is Low-Cost, Efficient Unit

An output of 2½ gallons per day of cold vapor for maximum benefits of vapor therapy is supplied with the new Walton Thera-Mist Cold Steam Vaporizer-Humidifier. The low-cost, portable unit is

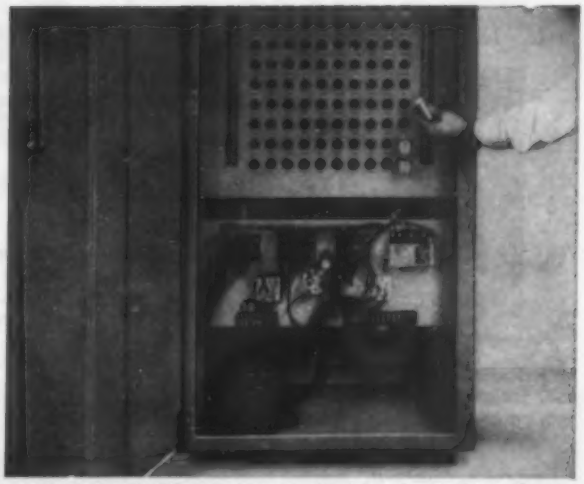


compact in design and has a directional vapor discharge that floats clouds of vapor toward the patient. One filling gives 12 hours of continuous operation. **Walton Laboratories, Inc., 1186 Grove St., Irvington, N.J.**

For more details circle #904 on mailing card.

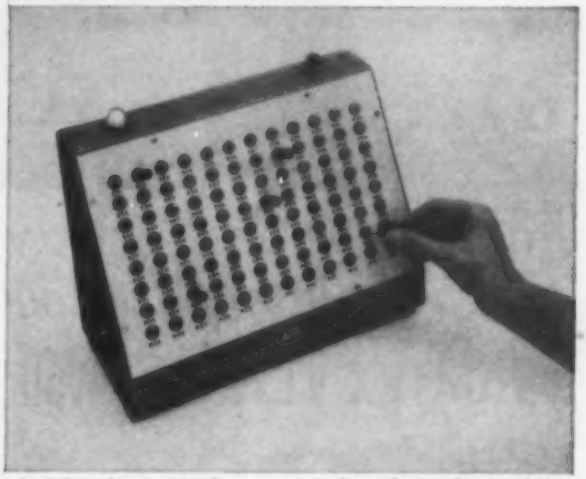
(Continued on page 212)

▲ *Doctors—entering and leaving—dial 3-digit code numbers on small Dial-Registers placed at convenient locations—then press the IN or OUT button.*



▲ *Their IN-OUT status is transmitted by electrical impulses to the control center. There the information is stored for release to any IN-Former which interrogates it.*

▲ *IN-Formers are used by the telephone operator and others to check any doctors' IN-OUT status by dialing his code number. Colored lights reveal his status.*



▲ *When the operator has a message for a doctor she signals him through a plugboard. This flashes a light signal on all Dial-Registers as he dials himself IN or OUT.*

"DIAL-IN"

—the Best Doctors' In-and-Out Register System for Large Hospitals

This unique new staff register system is really a boon to large hospitals. When a doctor is urgently needed much time can be saved—perhaps a life— by knowing immediately and reliably whether or not the doctor is in the hospital. In large-staff hospitals with a number of entrances—or a number of buildings—the problem of registering the coming and going of doctors has defied a satisfactory solution. Up to now conventional register systems have required too much space; too much installation expense; too much inconvenience and time-loss to doctors and hospital personnel. Now, the Auth "Dial-IN" system eliminates these obstacles and makes it possible for large-staff hospitals to know who is in within a few seconds—and it does this conveniently for everyone and at reasonable cost.

The "Dial-IN" System and other types of doctors' in-and-out register systems; nurses' call systems; and doctors' paging systems—all designed to increase the efficiency of your hospital—are manufactured by AUTH. A representative is ready to discuss them with you. No obligation, of course.

Auth SINCE 1892

Auth Electric Company, Inc.

LONG ISLAND CITY 1, NEW YORK

SPECIALISTS IN HOSPITAL SIGNALING AND COMMUNICATION SYSTEMS, CLOCK AND FIRE ALARM SYSTEMS

Ezon Glove Lubricant in Aerosol Spray Can

Packaged in an eight-ounce aerosol can, the Ezon Glove Spray is a specially formulated Spray Lubricant for use by surgeons and nurses when donning surgical gloves. It is sterile when dispensed and thoroughly tested through independent laboratories and in hospital operating rooms. For use, Ezon Glove Spray is sprayed in the hands and spread evenly through rubbing with a washing motion. **The Seamless Rubber Co., New Haven 3, Conn.**

For more details circle #905 on mailing card.

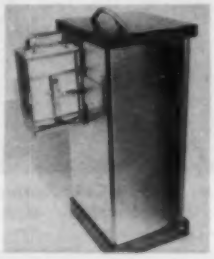
Flex-Straw Drinking Tubes Now in Six Cheery Colors

Designed to be used in pediatric wards and for young patients, the new pastel colored Flex-Straw drinking tubes come in six attractive shades. Flex-Straw drinking tubes bend at any angle, can be used with hot and cold liquids and are safe, sanitary and disposable. The gay new colors are equally cheery for use with adults and especially for geriatric or other long-stay patients. **Flex Straw Co., 1504 10th St., Santa Monica, Calif.**

For more details circle #906 on mailing card.

Pulmonor Saves Time In Waterless Pulmonary Tests

Considerable time is saved in making waterless pulmonary function tests with the new Pulmonor. In addition, the process is simplified with the portable low



inertia system. Features include inkless graphs, double sensitivity setting, variable volume shift and reversible timer for a wide range of flexibility to meet nearly every requirement for high velocity, low resistance tests and other volume measurements. **Jones Medical Instrument Co., 321 S. Honore St., Chicago 12.**

For more details circle #907 on mailing card.

Dura-Speed and Dura-D Screens in Ansco Line

Two new Intensifying Screens are introduced by Ansco. Dura-Speed is a high speed, fine grain screen for better definition with higher speeds. Dura-D is a medium speed, ultra fine detail screen. Both are designed for better film-screen contact, less static, easier cleaning, longer life, no pitting and consistent quality. **Ansco, Div. of General Aniline & Film Corp., Binghamton, N.Y.**

For more details circle #908 on mailing card.

Automatic Defrosting in Freezer-Refrigerator

A new 45-cubic-foot freezer and refrigerator introduced by Norlake features glass doors of the swing-out or sliding type and automatic hot gas defrosting.

Also included in the new line are a freezer, a refrigerator, and a combination unit with solid doors. All units feature moisture vaporizers to eliminate the need for drains. Frost is automatically removed as required with the new defrosting device. **Nor-Lake, Inc., Hudson, Wis.**

For more details circle #909 on mailing card.

(Continued on page 215)

FASTEST—MOST ACCURATE

PATIENT FOOD DELIVERY SYSTEM YET DEVISED!

Meals-on-Wheels

ELECTRA II

and the

TRAY-ON-TRAY

system

NOW tray matching made easier than ever! New side by side heated compartment trays match horizontally with corresponding refrigerated compartment trays. Hot and cold foods quickly combined while correct temperatures maintained at all times.

NOW the most important step yet toward elimination of confusion and delay. The *TRAY-ON-TRAY* concept of loading and serving makes it possible to place hot food tray on cold food tray more quickly with *NO* mistakes!

NOW dietitians easily check complete patient tray!

Supervisor can now check *complete* patient tray before it leaves the kitchen exactly as it will be delivered to the patient with hot foods *hot* and cold foods *cold*—guaranteed!

NOW recessed compressor allows more top working space—greater visibility. Beverage containers on right make serving easier—quicker. Six wheels for greater handling ease. Efficient ice cream freezer. Accommodates standard 8 oz. HT glass. Rugged corner construction. Four match-a-doors.

SEE BACK PAGE FOR MORE COMPLETE DETAILS

Get all the information on the new, thoroughly pre-tested Meals-on-Wheels delivery unit and *TRAY-ON-TRAY* system now!

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY MAIL

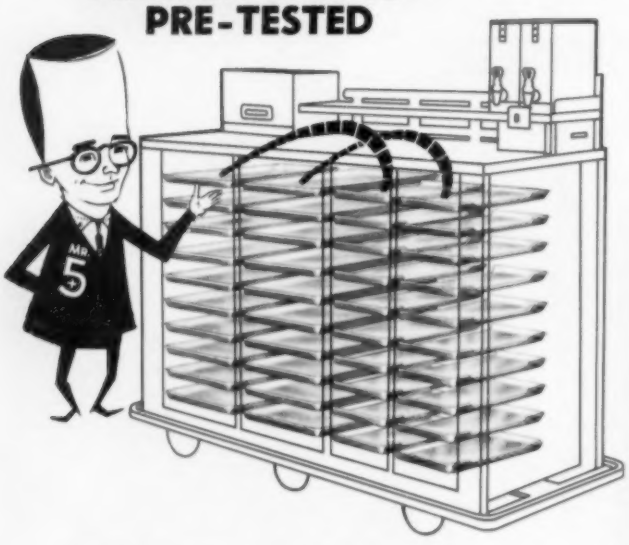
First Class Permit No. 5253, Sec. 34.9, P. L. & R., Kansas City, Mo.

Meals-on-Wheels System

5001 EAST 59th STREET

KANSAS CITY 30, MISSOURI

TRAY-ON-TRAY SYSTEM
WITH ELECTRA II— PROVEN IN USE— PRE-TESTED



Dotted lines in illustration show how easy it is, with Meals-on-Wheels TRAY-ON-TRAY System, to combine hot and cold foods.

The ELECTRA II with the TRAY-ON-TRAY system is YOUR answer to the problems of tray make-up, loading, and delivering tasty food to the patient.

The ELECTRA II means speedy and simple loading and final assembly. Gone forever are those costly mistakes in kitchen loading and delivery. As complete patient tray is ready for loading, hot food tray is removed from patient tray and placed in heated compartment. Next, patient tray is placed in refrigerated compartment horizontally matched to hot food tray. At patient area diet maid simply, with one motion, places hot food tray on companion patient tray exactly as it was made up and checked in the kitchen.

Meals-on-Wheels System

Please send me a copy of the all new ELECTRA II catalog with the *TRAY-ON-TRAY* concept.

Name _____ *Title* _____

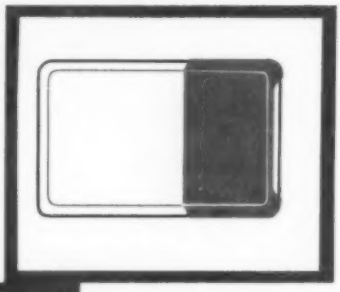
Hospital _____

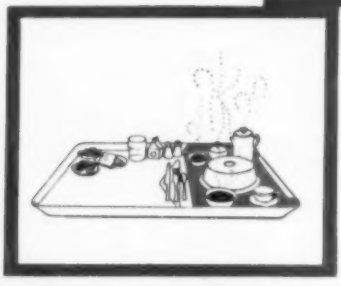
Street _____

City _____ *Zone* ____ *State* _____

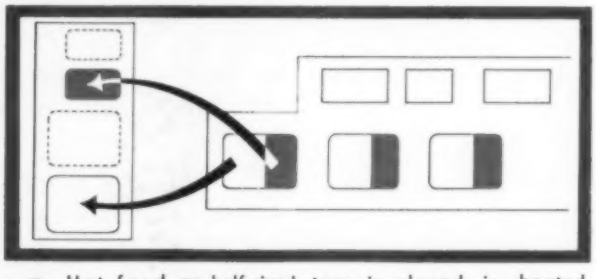
THIS IS HOW IT WORKS:

1 Half-sized hot food tray and patient tray combined at start of assembly line.

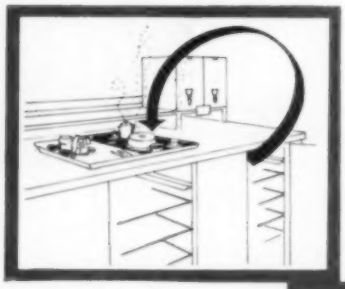




2 Hot foods are placed on the half-sized tray. Cold foods are placed on ample remaining area of patient tray.



3 Hot food on half-sized tray is placed in heated compartment. Patient's tray with cold foods, etc., placed in matching refrigerated compartment.



4 At patient area patient tray placed on ample, convenient working space and, in one easy motion, hot food tray is placed on patient tray. (If desired, hot items may be removed from half-sized trays and placed individually on patient tray.)

5 Tray delivered to patient with foods at their most palatable temperatures exactly as they left kitchen.

TRAY-ON-TRAY— the easy way— the quick way— the no mistake way!

Aluminum Patient Aids Now Have "Lumite" Finish

A special anodizing process for hardening aluminum surfaces to enable the product to retain its original bright luster for years of wear is now available on the full Lumex line of aluminum Patient Aids. Known as "Lumite," the finish eliminates smudged clothing and towels caused by surface oxidation of aluminum and protects the products. Patient Aids with the "Lumite" finish are offered without increased price. **Lumex, Inc., Bellmore, N.Y.**

For more details circle #910 on mailing card.

Motor Hydraulic EENT Chair Is Foolproof and Comfortable

A factory-sealed hydraulic mechanism makes the new Reliance No. 660 Motor Hydraulic EENT chair foolproof and easy

to operate. A single pedal on each side raises and lowers the seat of the chair and permits the patient to relax comfortably. Upholstery is leather or Naugahyde and the base is finished in baked enamel. **F. & F. Koenigkramer Co., 96 Caldwell Dr., Cincinnati 16, Ohio.**

For more details circle #911 on mailing card.

Room Type Humidifier Provides Controlled Humidity

Instantly controlled 85 to 90 per cent relative humidity at about five degrees over room temperature is provided with the Rotherm Room Type Humidifier, which combines a water container with an electrical heating element suspended above the water level. Steam is not visible as condensation does not form. The humidi-

fier is easily moved to any room and will give 12 hours of continuous operation on one filling. **Rotherm Engineering Co., Inc., 7280 Devon Ave., Chicago 31.**

For more details circle #912 on mailing card.

Minimum Volume Extension Set Has Check Valve at One End

Designed for anesthesiologists who want more reach with a syringe in administering medications intravenously or intraspinally, the Chexet M.V. is a minimum volume extension set with a check valve at one end. With the device, a syringe can be held at eye level to assure accurate plunger depression and the check valve stops back leak due to venous pressure or head pressure from blood or solution containers hooked into the line. The low-priced unit is completely disposable and comes packaged four to a pack. **Cutter Laboratories, Berkeley 10, Calif.**

For more details circle #913 on mailing card.

H & L Line Spray Products Are High Quality at Low Cost

High quality with low cost is claimed for the new line of Hospital & Laboratory Products. Known as the H & L line, the spray products are supplied in 12-ounce cans and include Skin Protector, Skin Freeze, Adhesive Tape Remover, Spray Bandage, Tincture of Benzoin and Room Deodorant. The spray packaging makes

them easy to use and store. **Alconox, Inc., 853 Broadway, New York 3.**

For more details circle #914 on mailing card.

(Continued on page 216)

For additional information, use postcard facing back cover.

Beverage Caddy in Two Models

Two mobile beverage Caddy models, T-502 with a dropped drain for pitcher filling and model T-501 with a flush type drain, permit kitchen prepared hot or cold beverages to be wheeled directly to the service area for dispensing. Both models are constructed of stainless steel and are moved easily on four swivel casters, two of which have foot brakes. **Caddy Corp. of America, Secaucus, New Jersey.**

For more details circle #915 on mailing card.

Telephone Ringing Signal Is Pleasing Chime

A pleasing telephone ringing signal is now available in the "Telchime" Series 1310. It is activated by an incoming call and emits a single bell tone at the beginning of the ringing cycle and a pleasing chime at the end, repeated at three-second intervals. The "Telchime" is especially suited for patient rooms and other areas where a sharp ringing might be disturbing. **Wheelock Signals Inc., Long Branch, N.J.**

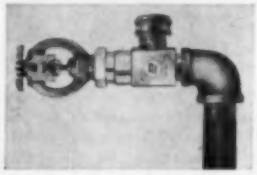
For more details circle #916 on mailing card.

Disposable Scalpel Has High-Tempered Blade

A featherweight, perfectly balanced scalpel, with a high-tempered blade affixed, is introduced by Sterilon in disposable plastic. The formfitting grip allows complete freedom of surgical dexterity and the Swedish steel blade is extra sharp and rigid with highly sensitive balance. The new Sterilon Scalpel is supplied sterile-wrapped in a double transparent envelope to permit complete asepsis upon entering a sterile field and is ready for instant use. It is available with Nos. 10, 11 or 20 blade styles. **Sterilon Corp., 500 Northland Ave., Buffalo 11, N.Y.**

For more details circle #917 on mailing card.

Seco Line Tester For Fire Protection Systems



The Seco Line Tester is an approved method for easy, fast testing of fire protection sprinkler systems to determine the condition of branch lines. As a permanent installation, the line tester complies with approved maintenance procedure and permits regular checking without shutting down the system. **Seco Mfg., Inc., 4461 W. Jefferson, Detroit 9, Mich.**

For more details circle #918 on mailing card.

Aluminum Elevating Cot Features Ease of Operation

Maximum headroom is provided with the new Model No. 32 Elevating Stretch-R-Cot, which permits operator efficiency in the handling and transfer of patients while increasing patient comfort. Features of the cot include fingertip controls for the four different height adjustments, an easy operating backrest combined with

the recessing bed, and side rails that swing down so the bed lays out flat for transfer of the patient by one person. Of strong Alcoa tubular aluminum, the 44-pound cot is equipped with a footrest, folding foot pull handle and folding side arms. **Ferno Mfg. Co., Greenfield, Ohio.**

For more details circle #919 on mailing card.

(Continued on page 218)

FOR TECHNIC PERFECTION IN BLOOD COLLECTION...

NEW B-D® VACUTAINER®

sterile disposable needle

reduces risk of cross-infection— a new, factory-sharp needle for every venipuncture

a B-D DISCARDIT product

SAFE
re-use is precluded... plastic hub cannot withstand conventional re-sterilization

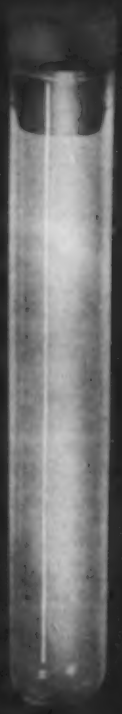
UNIQUE
the first truly disposable needle available for use with evacuated tubes

ECONOMICAL
preparation of needle and post-use handling eliminated

CONVENIENT
ready for immediate use... individually packaged in handy, sterile units

and B-D® VACUTAINER®

evacuated specimen tube



offers the **simplest** and most **efficient** means of obtaining quality blood specimens

PROVEN BY OVER 10 YEARS' EXPERIENCE

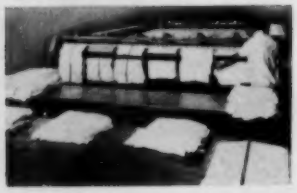
SUPERIOR STOPPER
easy to clean... easy to use... easy to remove...

STRAIGHT SIDE TUBE
easy pouring...easy pipetting of serum, plasma or whole blood... easy removal of clots

WIDE RANGE OF USES
six different sizes and 45 different anticoagulants and preservatives ...color-coded according to usage

BECTON, DICKINSON AND COMPANY
RUTHERFORD, NEW JERSEY

Flatwork Stacked Automatically With Tru-Stak Stacker



A simple machine, with no clutches or swinging arms, automatically stacks flatwork directly from the ironer. Called the Tru-Stak Stacker, it can be applied to any 120-inch flatwork ironer and is available with four, five or six stacking lanes. Pieces can be by-passed in any or all lanes without stacking when desired. The machine stacks towels, napkins, pillow cases and similar flatwork, and capacity is limited only by the ability of the feeding operators at the ironer. **American Laundry Machinery Industries, Cincinnati 12, Ohio.**

For more details circle #920 on mailing card.

Maysco Sterile-Tread Disinfects Shoes and Wheels

Designed to disinfect shoes, and wheels of rolling equipment, without interfering with normal work routines, the new Maysco Sterile-Tread is mounted on the floor at the entrances to operating suites, nurseries and delivery rooms. The custom-made unit is generally twelve feet long and practically as wide as the corridor or entry. It consists of a pan which contains a thin plastic sponge material covered with canvas. The sponge, saturated with a disinfectant solution, has sufficient resiliency to permit an imprint which forces the disinfectant to penetrate the canvas and contact the bottom and sides of shoe soles and wheels. A series of springs keeps the canvas cover wrinkle-free and permits easy passage of wheeled equipment. Produced by the **Mays Equipment Development Corp.**, the unit is sold by **National Cylinder Gas Div., 840 N. Michigan Ave., Chicago 11.**

For more details circle #921 on mailing card.

Compact Shroud Kit Has All Necessary Items

Low in price, the new Busse disposable Shroud Kit is a compact unit containing all the items necessary for handling of the deceased. The adult size has an opaque white plastic sheet, a chin strap, two cellulose pads, two ties and a plastic bag for personal belongings. **Busse Hospital Disposables, Inc., 64 E. 8th St., New York 3.**

For more details circle #922 on mailing card.

Aero-Master Insect Control Redesigned for Portability

A small, compact, portable model of the Aero-Master insect control system is now available for use in hospitals and other institutions, especially in food service areas. The compact unit is carried to the place of use and plugged into any outlet, ready for operation. The Aero-Master produces a dry fog which penetrates deeply into cracks and crevices, giving wall to wall and floor to ceiling coverage of the area for complete control of insects. The sturdily contructed unit has a jet micronizer and a capacity of one gallon, sufficient for two hours of operation. **Aero-Master, Inc., 325 W. Pacific Ave., St. Louis 19, Mo.**

For more details circle #923 on mailing card.

(Continued on page 220)

The bedsheet that fights germs

All over the country hospitals were alerted. Outbreaks of infection had been reported in several places. The cause: A well-known germ that had suddenly developed strains resistant even to modern miracle drugs.

Though isolated, these cases put medical centers into immediate action. No such menace could be given the faintest chance to spread through the nation's carefully run hospital system.

The germ was called *Staphylococcus aureus*, or "staph" as doctors nicknamed it.

Staph presented a many-sided problem. Visitors—even hospital personnel—could be carriers because the germ can be resisted by healthy adults. It is most dangerous to the newborn, the very old, and patients recovering from surgery.

Even more difficult, the fabrics used in hospitals—linens, uniforms, all materials that create lint—were suspect. For staph clings to lint and becomes airborne. The tiniest of lint particles raised by changing beds or normal walking in uniforms, were potential dangers.

No matter how often hospital staffs scrubbed floors and walls, no matter how carefully they followed strict rules for personal cleanliness, many airborne staph germs remained alive.

Today, the danger of staph-contaminated lint from blankets, mattresses, bed linens, and uniforms can be virtually eliminated by a new product developed, field tested, and proven by the Armour Industrial Soap Division called Velva-Soft-G®. Fabrics treated with Velva-Soft-G during the normal laundry operation arrest the growth of staph germs on contact. The fabrics keep their germ fighting ability from washing to washing.

A new high active Velva-Soft-G Concentrate is now available. It will treat the average patient's linens for approximately 2½¢ per day.

For technical information on the clinically proven antibacterial treatment for hospital linens with VELVA-SOFT-G, please write to: B. J. Augst, Manager.

ARMOUR AND COMPANY

Industrial Soap Division — **1355 West 31st Street, Chicago 9, Illinois**

For additional information, use postcard facing back cover.

Photostat Photocopier Makes Ten Copies Per Minute

Producing as many as ten copies per minute for as little as three cents per copy, the new Photostat 10.14 Photocopier is designed for fast reproduction of letters,

records and similar graphic materials. It provides high quality enlarged or reduced size photocopies from every type or color of subject up to 20 by 28 inches in size. Dry copies may be made on any of a dozen different types of Photocopy Paper and may vary in size to suit requirements. **Photostat Corp., 1001 Jefferson Rd., Rochester 3, N.Y.**

For more details circle #924 on mailing card.

Fluorescent Wall Fixture Lights Three Ways

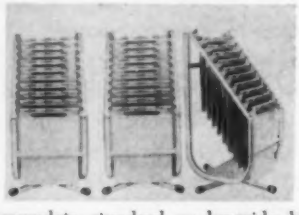
The Miller Multi-Purpose Wall Light features three distinct lighting types in one unit: downward, upward, or both.

Available in two, three and four-foot lengths, the fixture can be equipped with a four-way pull chain switch, an outlet for electrical appliances and a night light in the upper compartment, if desired, making it especially adaptable to installation over patient beds. **The Miller Co., Meriden, Conn.**

For more details circle #925 on mailing card.

Revolving Chart Rack For Increased Accessibility

Charts are accessible from either side of the desk as well as from any angle with the new Beam-Matic Chart Rack. The all-aluminum unit revolves in its own diameter of 13 inches and has 360-degree turntable action. Available in two sizes to



accommodate standard or longside hinge chart holders, the racks are of tubular construction and have an anodized finish. **Beam Metal Specialties, Inc., 25-11 49th St., Long Island City 3, N.Y.**

For more details circle #926 on mailing card.

(Continued on page 222)

When wax contains Du Pont anti-slip LUDOX® floors are safer...and they rebuff mirror-bright!

Floor wax containing "Ludox" colloidal silica is safer to walk on, and *stays* that way. When you rebuff this wax to give it a gloss as good as new, the anti-slip qualities remain. Tiny silica particles of "Ludox" provide millions of "grippers" that stay on the job, greatly lessening the tendency to slip. Other wax properties sacrificed? Not at all. You get the same lasting beauty and easy maintenance of regular fine waxes.

"Ludox" is Du Pont's registered trademark for its colloidal silica . . . an ingredient used by formulators of quality wax. Floor wax containing "Ludox" is available everywhere. If you'll mail the coupon, we'll send more information and a list of suppliers.

DU PONT REG. U.S. PAT. OFF. **LUDOX®** colloidal silica

BETTER THINGS FOR BETTER LIVING . . . *THROUGH CHEMISTRY*

E. I. du Pont de Nemours & Co. (Inc.)
Industrial & Biochemicals Dept., Rm. 2545MH
Wilmington 98, Delaware

Please send more information on floor waxes with "Ludox" and a list of suppliers.

*Name*_____

*Firm*_____

*Address*_____

*City*_____ *State*_____

Dor-O-Matic Toe-Gard Helps Prevent Accidents

Developed to help prevent accidents around automatic doors due to carelessness, the Dor-O-Matic Toe-Gard is applied along the full width of the bottom rail of automatically operated doors. Safe, effective protection is provided against toe and foot injuries. When the Toe-Gard plastic contact cushion touches a person or object in the path of the opening door, power operation is automatically stopped and the door backs a short distance away from the obstruction. It then resumes the opening cycle unless the obstruction remains, in which case it again stops. The Toe-Gard is designed for metal, tempered glass or wood doors equipped with the Dor-O-Matic Invisible Dor-Man door operator. **Dor-O-Matic Div., Republic Industries, Inc., 7350 W. Wilson Ave., Chicago 31.**

For more details circle #927 on mailing card.

Ozium Vaporizer Reduces Airborne Infection

When used continuously according to instructions, the new No. 2500 Ozium Vaporizer helps to reduce airborne infection by vaporizing Ozium concentrate. At the same time the compact, portable device, which can be placed on a table, desk or shelf and plugged into any 110 volt outlet, removes odors, leaving the air fresh and purified. Constructed to continually release sufficient vapors to treat an area up to 2500 cubic feet, the vapor-

izer utilizes one pint of Ozium Concentrate in 30 days, running continuously day and night. **Woodlets Inc., 2048 Niagara St., Buffalo 7, N.Y.**

For more details circle #928 on mailing card.

Fabromycin-Type Q Sanitizes Blankets

A quaternary ammonium compound formulated to sanitize blankets and bed linens as well as other fabrics used in the hospital is available in Fabromycin—Type Q. The compound is effective against many types of bacteria, including resistant strains of staphylococci and other gram positive micrococci. It remains on the washed fabrics after laundering, inhibiting contamination and any development of odor or mold-producing organisms. The product is non-volative, noncorrosive, and harmless to cotton, wool and synthetics. **Franklin Research, 5134 Lancaster Ave., Philadelphia 31, Pa.**

For more details circle #929 on mailing card.

Hamilton Beach Glass Washer for Nursery Bottles

Infant feeding bottles are quickly and thoroughly cleaned in the nursery with the Hamilton Beach Glass Washer. Up to

1200 bottles can be cleaned in an hour, providing considerable saving in nurses time. Four fast-revolving, motor-driven nylon brushes do the scrubbing and are available to fit various sized bottles. The glass washer has a convenient switch, rustproof, heavy duty construction and easily removed brushes. **Hamilton Beach, Div. of Scovill Mfg. Co., Dept. X-PR, Racine, Wis.**

For more details circle #930 on mailing card.

Televex X-Ray System Displays "Moving Picture" Studies

The new Westinghouse Televex system displays "moving picture" patient studies on remote screens, and simultaneously records images on film or video tape for playback and storage. The studies may be televised to one or more remote monitor screens. Radiation passing through the patient is picked up directly by an image amplifier, without any involvement of a fluoroscopic screen. The image is intensified about 1500 times and transmitted by

an optical system to a television camera, then to the monitor units to be viewed for study. **Westinghouse Electric Corp., 2519 Wilkens Ave., Baltimore 3, Md.**

For more details circle #931 on mailing card.

Continental Cuisine Food Is Individually Portioned

Armour introduces more than 20 prepared entrees and appetizers in its new Continental Cuisine Food Service line of individually-portioned dishes. Developed from international recipes as well as favorite American dishes, the foods are prepared under the personal direction of chefs with continental training. Individual portions are packed in compartmentalized flexible film pouches that separate the components, and are quick frozen for full flavor and quality retention. The pouches need only to be heated in boiling water for 10 to 12 minutes to be ready for serving. The new service provides flexibility in menus with virtually no additional preparation required. **Armour & Co., P.O. Box 9222, Chicago 90.**

For more details circle #932 on mailing card.

Model 3-A Electro-Air Unit for Single Room Use

The new "Single Room" Model 3-A Electro-air Cleaner has a 200 cfm capacity and is designed to remove smoke, pollen, dust, dirt and other air-borne particles from small areas, such as patient rooms, offices and conference rooms. Completely re-styled, it has a recessed instrument panel, beaded chrome trim and plastic control knob. The new electrical system has an automatic high tension connection and a new system of electrical interlock for safety and ease of servicing. **Electro-air Cleaner Co., Inc., Olivia & Sproul Sts., McKees Rocks, Pa.**

For more details circle #933 on mailing card.

Self-Adjusting Head Halter For Improved Treatment

The newly developed Daubenspeck head halter for improved treatment of cervical fracture of the vertebrae, osteochondritis and similar problems, ensures completely even pressure distribution on every part of the chin, neck and occiput. The patient is able to flex and rotate his head in the extended position without affecting traction. Irritating side pressure is

overcome by a simple sideways adjustment of the pulleys. **Orthopedic Equipment Co., Bourbon, Ind.**

For more details circle #934 on mailing card.

(Continued on page 224)

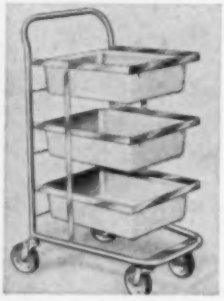
Remote-Control X-Ray Table Protects Radiologist

Designed to enable radiologists to increase their work load without loss of efficiency, the new Picker "Satellite" remote-control x-ray table and image amplifier system also eliminates radiation dosage. The physician, from a safe distance, can tilt the table, move the tabletop, open and close the shutter of the image amplifier, apply compression to the patient and shift at will from the TV viewing monitor to film recording for later study. All movements are motor driven, reducing fatigue and increasing efficiency. The remote control unit can be set up behind a protective screen in the same room with the patient if desired, and there are also controls on the table for close work. **Picker X-Ray Corp., 25 S. Broadway, White Plains, N.Y.**

For more details circle #935 on mailing card.

Weight and Cost Are Saved With Rugged Plastic Dish Box

Lightweight and relatively inexpensive, the new Jarvis & Jarvis polyethylene dish boxes are quiet in use and withstand hard wear. They resist acids and detergents, will not chip, shatter or dent, and are supplied with a new bussing station truck, Model 1260. The all-welded stainless chassis with 16 gauge, one-inch tubing and double-folded 18 gauge stainless steel box supports moves easily and noiselessly on five-inch swivel casters. The whole unit is easy to clean and trucks with boxes removed can be nested in minimum space for storage. **Jarvis & Jarvis, Inc., Palmer, Mass.**



For more details circle #936 on mailing card.

"Tonecrete" Decorative Coating Is Fire Resistant and Durable

Highly fire-resistant, "Tonecrete" is an inorganic coating which does not suffer from the deteriorating effects of oxidation and weather exposure. It is durable and decorative and forms a continuous, unbroken film over any number of base surfaces. It is designed for both interior and exterior application and may be applied over most materials, including pre-fabricated steel buildings, metal roof decking and siding. It is available in a wide range of colors and textures. **Desco Vitro-Glaze Assn. of America, Box 74, Buffalo, N.Y.**

For more details circle #937 on mailing card.

Savings in Water Consumption With Easy Push Metering Shower

An adjustable metering valve with an integral volume control for regulating the water supply is a feature of Speakman's Easy Push self-closing metering shower, which offers considerable savings to institutions with multiple shower installations. When the Easy Push handle is pressed down, the shower gives up 4½ g.p.m. of tempered water and shuts off automatically, so that water is not wasted while the user is soaping. The handle is pressed again when he is ready to complete his shower. **Speakman Co., 30th & Spruce Sts., Wilmington, Del.**

For more details circle #938 on mailing card.

(Continued on page 226)

Dish Table Mats Have Green Plastisol Coating

Heavy green plastisol coating cushions china and prevents chipping and breakage with the new Seco Dish Table Mats. The wire frame and cross members are welded together at all contact points and feet formed integrally with the frame hold mats off table and sink tops for thorough drainage. The new mats are available in 12 and 18-inch widths in three standard sizes to fit 24, 30 or 36-inch dish tables. **Seco Company, Inc., 4560 Gustine Ave., St. Louis 16, Mo.**

For more details circle #939 on mailing card.

Trend Series Luminaires Designed for Visual Comfort

High-level illumination is provided at recommended standards for visual comfort with the new line of Trend Series fluorescent luminaires. Attractive, luminous wrap-around side panels and efficient diffusers are included in the design, resulting in higher foot-candle levels. A choice of three diffusers is offered. **Lighting Products, Inc., 2225 West Park, Highland Park, Ill.**

For more details circle #940 on mailing card.

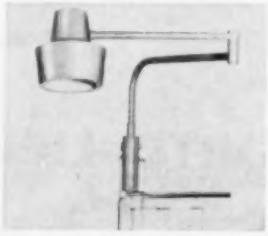
Vinyl Wall Covering Added by Congoleum-Nairn

Wall-Ever Vinyl is the trademarked name of the top quality vinyl wall covering added by Congoleum Nairn to its line of vinyl floor coverings. Offered at an unusually low price, the product features a heavy duty vinyl wear layer combined with an exclusive backing of vinyl felting. Installation is simplified due to extremely rapid adhesive absorption and excellent adherence, even on non-porous surfaces. It is highly resistant to cracking, gauging and scratching, and has top ratings for non-flammability, tensile strength, color fastness and dimensional stability, as well as to acids, alkalis, grease, oils, inks, extreme temperatures and frequent detergent washings. **Congoleum-Nairn, 195 Belgrove Drive, Kearny, N.J.**

For more details circle #941 on mailing card.

Nightingale Bed and Floor Lamps Are Readily Adjustable

Two new hospital lamps, one for mounting in overbed frame sockets to save floor space and the other in a floor stand, are



added to the Nightingale line. Model 148 for overbed mounting is a complete, functional lighting unit with a 3½-foot horizontal reach, making it effective for examination and applying dressings. The Bedside Floor Lamp Model 417 provides a 20-inch horizontal reach with height adjustment from 38 to 58 inches above the floor. Both lamps are readily adjusted, have double-walled ventilated reflector, 7½-watt night light and handy plug-in receptacle with patient-controls, and are approved by Underwriters Laboratories. **Adjustable Fixture Co., 104 E. Mason, Milwaukee 2, Wis.**

For more details circle #942 on mailing card.

Clear Plastic Oxygen Canopy Is Electronically Sealed

Available for all oxygen tents, the new Gaymar Disposable Oxygen Canopy is

electronically sealed for positive protection against air or gas leakage. The clear vinyl plastic tent is equipped with easy access plastic zippers. **Gaymar Industries, Inc., 701 Seneca St., Buffalo 10, N.Y.**

For more details circle #943 on mailing card.

Fluoromar Inhalation Anesthetic Allows Quick Recovery

Ohio Chemical introduces Fluoromar, a clear colorless liquid having a mild, unobjectionable odor. It is a stable inhalation anesthetic agent resulting from over five years of exhaustive animal experimentation and human clinical evaluations. It produces rapid induction, usually free of excitement, and allows quick recovery with early return of protective reflexes. Compatible with all other anesthetic agents and commonly used adjuncts, and adaptable to all popular anesthesia technics, Fluoromar may be used in all volatile liquid vaporizers. **Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis.**

For more details circle #944 on mailing card.

Sterile Prep Set Has Disposable Supplies

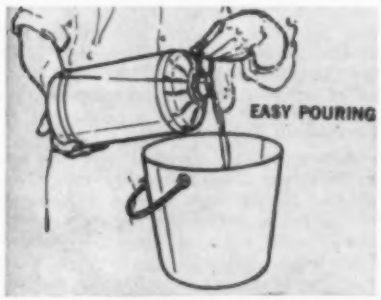
The danger of cross infection in prep routines is reduced with new Davol 3P (Personal Patient Protection) Prep Set containing completely functional and labor-

saving expendables for skin preparation at one source, for one patient only. The sets are fully disposable and can be stored at a variety of sites for instant use. The packages are rendered completely aseptic by penetrating electron beams in a special processing vault in the plant of High Voltage Engineering Corporation. Each Prep Set contains a multi-cupped plastic tray with plastic coated towel, cotton balls, two absorbent towels and a disposable razor with blade attached. **Davol Rubber Co., Providence 2, R.I.**

For more details circle #945 on mailing card.

Maintenance Cleaning Materials in Semi-Rigid Plastic

Sturdy, lightweight, semi-rigid plastic containers now hold seven of the maintenance cleaning materials in the Hysan institutional line. The one-gallon translucent polyethylene Poly-Bottle has a strong,

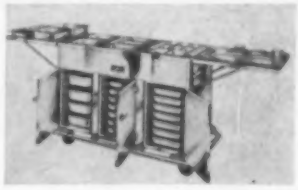


full-grip plastic handle for easy carrying, permits constant observation of the liquid level, does not break or rust, and weighs only five ounces empty. There is no product deterioration and the specially designed lip makes pouring easy. **Hysan Products Co., 932 W. 38th Pl., Chicago 9.**

For more details circle #946 on mailing card.

Hot and Cold Food Cart Keeps Food Ready for Serving

Designed to store food prepared well in advance of serving time, the new Atlas Model 573 Portable Electric Hot and Cold Food Cart can be transported to floor kitchens or other serving areas with food held at proper temperatures for service. The self-contained unit has top covers opening out to function as full serving shelves, and may be plugged into any standard electric outlet. The interchangeable top deck equipment will handle varying requirements of diversified menus and special diets. The top deck and two



lower compartments keep hot food hot, and the cold compartment keeps cold foods fresh and crisp. **Atlas Div., National Cornice Works, 1323 Channing St., Los Angeles 21, Calif.**

For more details circle #947 on mailing card.

(Continued on page 228)

Pharmaceuticals

Camoprim

A new antimalarial preparation is introduced in Camoprim, effective against all stages of the malarial parasite in man. It combines Camoquin with primaquine for use as a suppressive, a prophylactic and as an agent in eradication programs. Amodiaquin (Camoquin) destroys the infective malarial agents in the blood, while primaquine destroys the tissue forms and also the stages at which the disease is transmitted back to the mosquito. Camoprim is available as a tablet for adults or as "Infatabs" for children. **Parke, Davis & Co., Detroit 32, Mich.**

For more details circle #948 on mailing card.

Mysteclin-F Capsules

Mysteclin-F provides a new form of phosphate-potentiated tetracycline combined with an antifungal antibiotic for simultaneous antimicrobial therapy and antimonilial prophylaxis. The capsules are supplied in bottles of 16 and 100, half-strength capsules in bottles of 16, and Mysteclin-F is also available in a syrup and for aqueous drops. **E. R. Squibb & Sons, 745 Fifth Ave., New York 22.**

For more details circle #949 on mailing card.

Permitil Chronotabs

Sustained action to relieve ordinary anxiety and tension without impairing alertness for 14 to 16 hours is provided with Permitil Chronotabs. The tranquilizer contains 1 mg. of Permitil, half of which is in the outer coating for immediate absorption and the other half in the barrier-protected inner core for sustained action. **White Laboratories, Kenilworth, N.J.**

For more details circle #950 on mailing card.

Somacort

A new anti-inflammatory, muscle relaxant/analgesic compound is introduced as Somacort. A combination of carisoprodol, a potent muscle relaxant with analgesic action, and prednisolone, it is indicated for acute and chronic arthritis. It is also indicated for chronic and acute musculoskeletal disorders characterized by inflammation, stiffness, pain, muscle spasm and limitation of motion. Somacort is supplied in scored tablets in bottles of 50. **Wallace Laboratories, Cranbury, N.J.**

For more details circle #951 on mailing card.

Triaminic Concentrate

A new pediatric oral dosage form, Triaminic Concentrate is administered to decongest and promote drainage of nasal and paranasal passages, and to prevent or arrest histamine-induced damage. **Dorsey Labs., 200 N. 15th St., Lincoln 8, Neb.**

For more details circle #952 on mailing card.

Cardioquin Tablets

A new organic quinidine molecule for the treatment of cardiac arrhythmias, Cardioquin tablets each contain 275 mgm. of quinidine polygalacturonate, equivalent to 200 mgm of quinidine sulfate. Long term clinical studies indicate that the drug restores normal sinus rhythm without undesirable gastrointestinal side effects. **The Purdue Frederick Co., 135 Christopher St., New York 14.**

For more details circle #953 on mailing card.

(Continued on page 230)

Literature and Services

• A 108-page **catalog supplement SP-64** featuring many new items in the expanding Kimble glass line is presented by the Kimble Glass Co., a subsidiary of Owens-Illinois, Toledo, Ohio. Included in the supplement is information on Kimax flasks, small sized pipettes. Teflon stopcocks and other Kimax ware.
For more details circle #954 on mailing card.

• An attractively illustrated folder tells how to **"Beautify bare hospital walls with Foto Murals."** "Before and after" photographs show the interest and charm and the dramatic, decorative effects possible with Foto Murals, 8401 Wilshire Blvd., Beverly Hills, Calif.
For more details circle #955 on mailing card.

• **"Hospital Sepsis: A Communicable Disease"** is the title of a new medical film sponsored by Johnson & Johnson and available for showing through The Princeton Film Center, Inc., P.O. Box 431, Princeton, N.J. Demonstrating the spread of infection through the hospital by use of an actual case makes the film of particular interest to hospital administrators and department heads.
For more details circle #956 on mailing card.

• A 48-page booklet, **"For Better Steaming,"** on the advantages of steam cooking, its uses, methods, the cooking time for various foods, and a guide to the selection of steam cooking equipment, is offered by the Cleveland Range Co., 971 E. 63rd St., Cleveland 3, Ohio.
For more details circle #957 on mailing card.

• The complete line of **Chemclad plastic-laminate faced doors** is described and illustrated in a four-page brochure available from Bourne Mfg. Co., 1573 E. Larned St., Detroit 7, Mich.
For more details circle #958 on mailing card.

• The Metropolitan line of fountain and soda units, and the Superior line of soda units are described and illustrated in a new 12-page **catalog, No. S-111,** available from Bastian-Blessing Co., 4205 W. Peterson Ave., Chicago 46.
For more details circle #959 on mailing card.

• **"Comfort Conditioning With Light and Air"** is the title of a 24-page catalog (F 9768) containing complete information on combination light and air diffusers. Briefly stating the history and evolution of lighting and air distribution, the booklet, prepared by the Barber-Colman Co., 1300 Rock St., Rockford, Ill., and Day-Brite Lighting, Inc., 6260 N. Broadway, St. Louis 15, Mo., includes drawings illustrating how the new combination light and air diffusers are installed and balanced.
For more details circle #960 on mailing card.

• The Condec line of engine-driven electrical generating systems in the range of ten to 200 kilowatts is described in a seven-page booklet entitled **"Power Units."** Uninterrupted power supplies and adverse environmental power units are among the products featured in **Bulletin P-1,** available from Consolidated Diesel Electric Corp., 880 Canal St., Stamford, Conn.
For more details circle #961 on mailing card.

• **Catalog 2400** describes the complete Penco line of industrial and commercial steel shelving and illustrates the units by photographs or drawings. Available from Penco Div., Alan Wood Steel Co., 200 Brower Ave., Oaks, Pa., the 36-page booklet discusses typical applications and lists specifications.
For more details circle #962 on mailing card.

• Young wheeled equipment for commercial, industrial and institutional use is described and illustrated in **Catalog No. D-63,** available from Paul O. Young Co., Line Lexington, Pa. The 30-page booklet includes information on several new sizes and styles of utility carts, and features a new line of shelf trucks identified by the brand name "Serv-i-Carts."
For more details circle #963 on mailing card.

• The 13 **"Kalcolor" architectural anodic finishes** available from Kaiser Aluminum & Chemical Sales, Inc., Dept. NR-42, 300 Lakeside Drive, Oakland 12, Calif. are described and pictured in a 16-page booklet available from the company. A complete description of the anodizing system and details of testing are included with specifications.
For more details circle #964 on mailing card.

• Detailed illustrations and specifications covering all elements of Lumi-Flo troffers, which provide light, cool air and warm air from the same concealed ceiling fixtures, is available in a **44-page catalog, Bulletin B,** offered by the Benjamin Div. Thomas Industries Inc., 207 E. Broadway, Louisville 2, Ky. A special section describes the Benjamin research and engineering laboratories in Des Plaines, Ill.
For more details circle #965 on mailing card.

(Continued on page 232)

TROY Fleximatic Air Jet Folder giving sheets two folds at Terminal Steam Laundry in Glendale, N. Y.

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AMAZING "ELECTRONIC BRAIN" controller measures linens, locates folds and directs folding in halves and quarters 100% automatically.

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• Details and specifications on **Vogt Automatic Tube-Ice Machines** are presented in a new 8-page **Bulletin TI-4** presented by Henry Vogt Machine Co., P. O. Box 1918, Louisville 1, Ky. Background information on the development of the Tube-Ice Process is presented with descriptive information on the machines, illustrations of some uses of Tube-Ice and of installations of the equipment.

For more details circle #966 on mailing card.

• **Research Report No. 1323, "A Study of Methods of Grease Removal from Commercial Kitchen Exhaust Air,"** discusses problems involved in the removal of grease from institutional kitchen exhaust air and describes the construction and performance of an experimental grease vapor removal type gas fired incinerator. Copies of the report are available from the American Gas Association Laboratories, 1032 E. 62nd St., Cleveland 3, Ohio, where the research was carried on, or from the association headquarters, 420 Lexington Ave., New York 17, at $1 per copy.

For more details circle #967 on mailing card.

• A hospital training film depicting scenes from the housekeeping program of the Medical Center of the University of Mississippi is available through Vestal, Inc., 4963 Manchester Ave., St. Louis 10, Mo. Entitled **"The Big Three,"** the 16mm sound and color film sets forth three basic procedures of cleaning and asepsis with special emphasis on their applications to the three strategic areas of a hospital, the operating and delivery room and nursery.

For more details circle #968 on mailing card.

• Pictures and descriptions of the complete line of **commercial refrigeration equipment** manufactured by McQuay, Inc., 1600 Broadway St., N.E., Minneapolis 13, Minn., are supplied in a new 16-page catalog, including specifications, tables, capacities and accessories.

For more details circle #969 on mailing card.

• How better patient care can be provided with **disposable paper service for meals and snacks** in hospitals is discussed in a booklet available from Dixie Cup, Easton, Pa.

For more details circle #970 on mailing card.

• The 1960 edition of **Aluminum Window Specifications** is available from Aluminum Window Mfrs. Assn., 630 Third Ave., New York 17. Incorporating many changes since last published in 1958, the 32-page booklet is divided into three sections, general, specific and hurricane requirements.

For more details circle #971 on mailing card.

• **Traylifts and Traybelts by Standard** are the topic of a 12-page illustrated booklet identifying and qualifying the products in the line. Available from Standard Conveyor Co., North St. Paul 9, Minn., **Bulletin No. 120** offers data and general specifications on mechanized dish handling systems for hospitals and schools.

For more details circle #972 on mailing card.

• A current review of the clinical significance of Codeine is available in a new expanded edition of **"Codeine Today,"** a 14-page booklet offered to the profession without charge by the Merck Chemical Div., Merck & Co., Inc., Rahway, N.J.

For more details circle #973 on mailing card.

• The revised **1961 catalog of Maintenance products** manufactured by Zep Mfg. Corp., 1310 Seaboard Industrial Blvd. N. W., Atlanta 18, Ga., is a 68-page, plastic-bound book. Descriptive information is included for the full line of maintenance and sanitation supplies as well as tools and equipment.

For more details circle #974 on mailing card.

• A new booklet called **"The Revolutionary Tucker High Window Washer"** describes the window washer in detail and explains how this equipment will cut maintenance time in half, prevent costly accidents and reduce supply costs. Available from Tucker Mfg. Co., 112 Fourth Ave. S.E., Cedar Rapids, Iowa, the colorful brochure illustrates the diverse institutional uses of the unit.

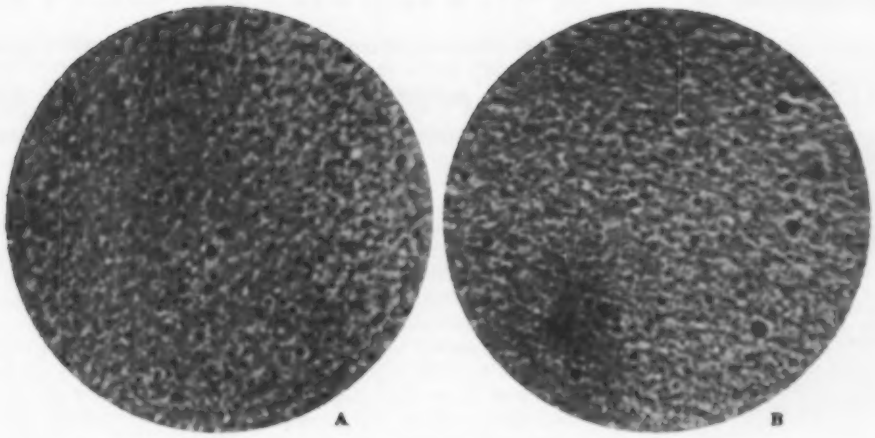
For more details circle #975 on mailing card.

• **"Facts about Vanilla"** are presented on one of a set of quantity dessert recipe cards offered by the Vanilla Information Bureau, Institutional Dept., Empire State Bldg., New York.

For more details circle #976 on mailing card.

Supplier's News

Edwards Company, Inc., Connecticut Ave., Norwalk, Conn., manufacturer of electric and electronic control, communications and protection equipment, introduced its new corporate symbol and signature recently. Designed to reflect the progressive outlook of the company, the new symbol consists of a bold letter "E" centered within an inverted triangular shield.



Which is chyle and which is Lipomul I.V.?†

As you know, after digestion, fat passes as an emulsion called chyle through the lacteals into the lymphatics tributary to the thoracic duct, and then into the systemic circulation. Lipomul I. V., like chyle, is a fine milk-white emulsion of fat. Its fat particles approximate those of chyle in size: about *1/7 the diameter of the normal red blood cell.* Because of this minute particle size, like chyle, Lipomul I. V. is *non-irritating to the vein.* The fat provides *8 times more calories* per cc. than does 5% glucose and with markedly increased protein-sparing action. It is *swiftly* and *completely metabolized.* Therefore, when formation of chyle, a major source of calories, is blocked during pre- and post-operative "digestive tract bypass," many surgeons add Lipomul I. V. to their standard fluid and electrolyte regimen to provide the most concentrated source of energy.

†A—Mammalian chyle (highly magnified)
B—Lipomul I. V. (highly magnified)

Formula:

Cottonseed oil	15% w/v
Dextrose anhydrous	4% w/v
Lecithin	1.2% w/v
Oxyethylene oxypropylene polymer	0.3% w/v
Water for injection	q.s.

Supplied in 250 cc. and 500 cc. bottles

Indications and effects

Lipomul I. V., fat emulsion for parenteral use, supplies approximately 400 calories per 250 cc. It is indicated in patients who are unable to take adequate food by mouth for any considerable period of time.

Administration and dosage

Administer only by intravenous route, as follows:

For adults

First 5 minutes	10 drops/minute
Next 25 minutes	40 drops/minute
Then	60 drops/minute

For infants and children

First 5 minutes	5 to 10 drops‡/minute
Next 25 minutes	0.5 to 1 drop per pound/minute
Then	0.5 to 1 drop per pound/minute

‡1 cc.—approximately 20 drops.

Precautions and side effects

To administer, use only the recipient set supplied in the package; Lipomul I. V. must not be mixed with transfusions, infusions, or any other parenteral medication, or be given simultaneously through the same tubing. A total of not more than 14 units (500 cc. each), at a rate not exceeding 2 units per day, should be given to any one patient.

Reactions of a "colloid" type may occur, including back or chest pain, dyspnea, severe flushing, or urticaria. There may be delayed chill. Transient fever has also been noted, as have such other minor reactions as nausea, vomiting, abdominal discomfort, headache, mild flushing, dizziness, and some variations in blood pressure and pulse.

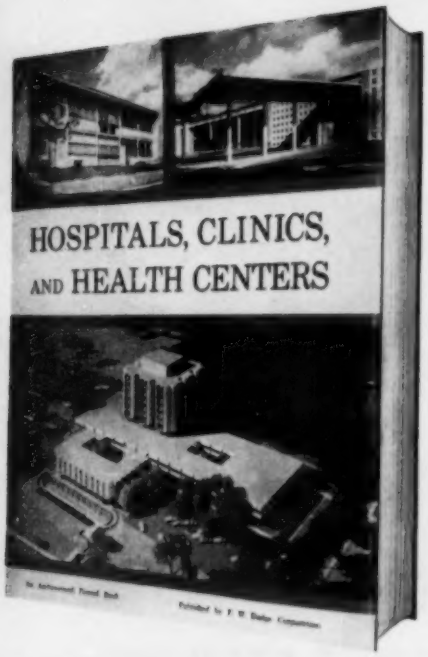
When the recommended dosage is exceeded, an "overloading syndrome" may occur characterized by chill, fever, abdominal pain, nausea, vomiting, hepatomegaly, clotting defects, thrombocytopenia, and bleeding, particularly from the gastrointestinal tract.

Lipomul I.V. Upjohn

Trademark, Reg. U. S. Pat. Off.

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

75th year



New illustrated survey of medical buildings

HOSPITALS, CLINICS, AND HEALTH CENTERS

by the editors of Architectural Record

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700 photographs, plans, and diagrams
Only $9.75

Here, in one book are the newest, most effective ideas for the planning of hospitals and other medical facilities. Divided into four major sections, this valuable sourcebook covers practically the entire range of medical building types: hospitals, special facilities, rehabilitation centers, health centers, clinics, and doctors' offices.

Containing sixty presentations and discussions, HOSPITALS, CLINICS, AND HEALTH CENTERS thoroughly examines the latest advances in medical building design. Each project studies a particular planning problem and its solution, and is graphically illustrated with numerous interior and exterior photographs, floor plans, and diagrams. Carefully choosen for their value, variety, and lasting interest, they provide vital background information needed to solve planning problems effectively.

Also included are authoritative technical articles on planning such specific elements as X-ray suites, pediatric units, and surgical suites. In addition it thoroughly analyses these important subjects: efficient handling of hospital traffic, planning of supply systems, air distribution in operating rooms, hospital electrical facilities, design of teletherapy units, and mechanical and electrical systems for health centers.

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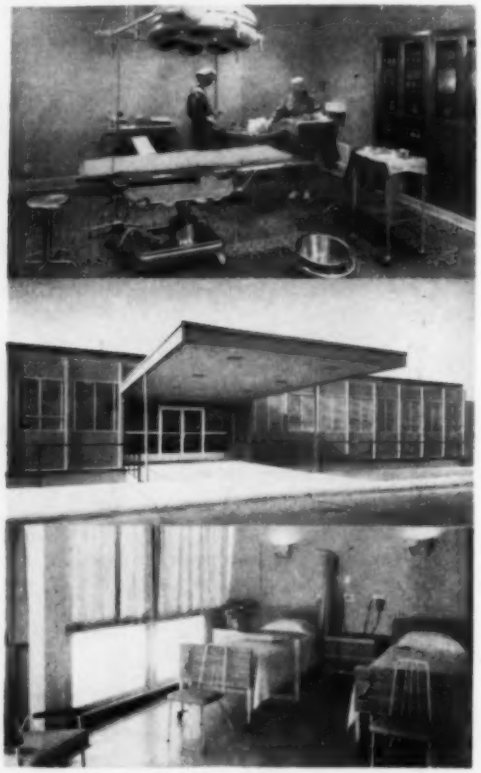

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INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

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